ANNEX 3

Background Paper on Children Affected by AIDS in Zimbabwe

CONTENTS

EXECUTIVE SUMMARY

BACKGROUND

In recent years, Zimbabwe has experienced declines in many of the social indicators that made the country the showpiece of sub–Saharan Africa in the 1980's. Infant, child, and maternal mortality are all rising, and primary school completion rates are falling. The causes of the changes witnessed in the last few years are multiple and complex.

The human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) epidemic has contributed to these reverses over the last few years through increased mortality, increased health care costs at the macro level, and reduction in household income and savings at the micro level. Real per capita spending by the government on health, basic education, agriculture, and social welfare have all fallen substantially. Government budgetary deficits and resultant high inflation have had adverse effects upon the economy. Though up-to-date figures are not available, the deterioration of the economy, user fees, and other adverse factors appear to have had a major impact on children's access to health care and education.

Projections from Zimbabwe's National AIDS Control Program (NACP) estimate that 670,000 children (1 in 6 children under 18) will be maternal or double orphans by the year 2000, due to AIDS. In response to this looming crisis, USAID/Zimbabwe commissioned this background paper on children affected by HIV/AIDS. Research and interviews were conducted in January and February 2000. The paper serves two basic purposes. First, as originally intended, it provides a foundation for USAID actions to enhance capacity at the regional and local levels, leading to possible interventions such as increased support for community responses to children and families affected by the epidemic.

Second, pending the availability of a true nationwide analysis of HIV/AIDS interventions, this paper serves to highlight unanswered questions about the impact of HIV/AIDS on Zimbabwean children. Examples include questions such as how the government of Zimbabwe (GOZ), donors, and others can coordinate and communicate about their efforts to mitigate the impact in children. For this reason, this paper is intended to be shared with government, donors, and other actors in the fight against HIV/AIDS.

The HIV/AIDS epidemic is leaving increasing numbers of vulnerable children in need of special care and protection. Children are affected by AIDS in many ways, from the burdens of caring for sick parents and younger siblings, to the absence of a mother who is caring for a family member in another household, to the loss of income and work as adults become ill or die, to the loss of capital expended on medications and funerals.

In severely affected communities, HIV/AIDS has an impact on children, families and communities that is incremental. Continuous deaths among young adults lead to social and economic consequences that increase with the severity and duration of the epidemic. The effect of HIV/AIDS on children and families is compounded by the fact that many families

live in communities that are already disadvantaged by poverty, poor infrastructure, and limited access to basic services.

The specter of increased numbers of children growing up who are highly susceptible to HIV infection hangs over this generation: of hundreds of thousands of children living on the streets or in destitute, child-headed households; of teenage orphan girls providing survival sex favors in exchange for money or food; of children leaving school to work alongside adults in a neighbor's fields or leaving the family to work as a domestic; or of young unsupervised children being abused or exploited.

Perhaps nowhere is the imperative to link the provision of care and support activities to HIV prevention seen more clearly than with children affected by AIDS. Care programs are an ideal entry point for prevention programs and have the potential to be effective in preventing the future transmission of HIV.

It is difficult to envision the possibility of protecting children affected by AIDS from exploitation and preventing them from becoming HIV–infected unless their basic needs are met. Strengthening the efforts of communities responding to children affected by AIDS is not only an investment in development—it is also an investment in the prevention of future HIV infection and an investment in the shrinking HIV epidemic.

RESPONSES TO CHILDREN AFFECTED BY HIV/AIDS

Local Responses

Approximately 100 community-based organizations (CBOs) have been established in Zimbabwe to assist children affected by AIDS. Community groups are working in rural, urban, and commercial farm sectors. Responses are focused on all orphans, not only on children orphaned by AIDS, and support is normally provided to other vulnerable children as well. Most activities provide support to the entire community, not just to members of one church, group, or clan.

The types of community organizations that have established programs to support children affected by AIDS and the ways in which programs have been established are diverse. Many are church groups, which already have a religious mandate and an existing interest in supporting widows and orphans. Volunteers have established programs sometimes simply as a result of seeing the need in their community or by hearing of a similar program elsewhere. Some groups have been assisted by nongovernmental organizations (NGOs), or by staff or volunteers working with denominational umbrella body organizations, such as the Evangelical Fellowship of Zimbabwe (EFZ) or the United Methodist Church.

Traditional leaders with an existing interest in providing for the poor in their communities have revived or extended traditional mechanisms of support for orphans, sometimes with help from the Department of Social Welfare (DSW) and the United Nations Children's Fund (UNICEF). Some community groups have initially been involved in providing home

care services and have extended these programs to provide visits and material support to households with orphans.

Of the 150 support groups for people living with HIV/AIDS (PLWHAs) listed in the *Zimbabwe 1999 Directory*, 13 list orphan support as one of their activities. Many PLWHA groups provide support to families of the deceased, which later develops into support programs for other children affected by AIDS.

Community-based initiatives provide support to children affected by AIDS through the following mechanisms:

- Identifying and monitoring the most vulnerable children through household visiting;
- Providing care and psychosocial support;
- Supporting community coping mechanisms through material support;
- Supporting income-generating activities, gardens, and revolving credit funds;
- Providing practical help and livelihood assistance;
- Providing household training;
- Supporting recreational activities;
- Developing creche and child-minding facilities;
- Creating community foster homes;
- Supporting HIV prevention activities;
- Providing volunteer training and motivation;
- Developing registration systems; and,
- Establishing child welfare forums.

Government, Advocacy, and Donor Responses

There are several key national policies and plans under development by the GOZ that will affect children's rights and welfare, including the development of a new constitution, a newly launched HIV/AIDS policy, and draft policies on youth and orphans, economic decentralization, and land reform policies. These policies may have a positive or negative effect on children, depending on the extent to which children's rights are acknowledged, prioritized, and put into action.

In 1999, the government increased its commitment to addressing HIV/AIDS through the implementation of a national HIV/AIDS policy, the initiation of an "AIDS levy" (a 3 percent surcharge on taxation), and the establishment of a national AIDS council (NAC) to facilitate a multisectoral government approach. The NAC, led by a presidential appointee, will assume responsibility for HIV/AIDS resource mobilization, policy development, and overall coordination of HIV/AIDS programs.

Advocacy for Zimbabwean children affected by AIDS will become increasingly critical as their numbers increase. Because gender is such a significant issue affecting the impact of HIV/AIDS on women and their families, advocacy for women is also critical to the welfare of children affected by HIV/AIDS. UNICEF has been a leading child advocate in Zimbabwe, and its role is significant.

There are few donors currently supporting efforts to enhance the capacity of community responses to children and families affected by HIV/AIDS. USAID/Zimbabwe has the opportunity to take a leading role in supporting community responses through activities such as the development of innovative implementation mechanisms that use existing structures at all levels.

Donors presently involved in providing assistance to children affected by HIV/AIDS in Zimbabwe include UNICEF, Redd Barna, the Danish Development Agency (DANIDA), the Canadian International Development Agency (CIDA), the Oak Foundation, the Norwegian Organization for Relief and Development (NORAD), the Swedish International Development Agency (SIDA), and the Save the Children Fund.

PROPOSED PRINCIPLES OF ACTION

This report offers the following principles of action as a starting point for dialogue. The expectation is that donors and other actors will adapt these or similar principles for their work.

In general, community responses to the needs of children affected by HIV/AIDS should:

- not single out AIDS orphans—targeting specific categories of children potentially leads to increased stigma and discrimination and ultimately causes harm;
- direct assistance to the most vulnerable children and households, regardless of the specific causes of their vulnerability; and,
- encourage the development of a system to prioritize assistance through a representative and participatory process involving communities and affected children.

Specific suggestions for taking action include:

- **Strengthen Care and Coping Capacities of Families and Communities**

The scale of the pandemic is causing enormous strain on the traditional coping mechanisms of the extended family, eroding its capacity to care for those suffering from or left behind by HIV/AIDS. Enhancing the capacity of responses by families and communities to address the needs of children/youth affected by HIV/AIDS may be the most effective, efficient, and sustainable approach to fill the widening gaps in traditional safety nets.

- **Minimize Unintended Consequences – Do Not Undermine Community Efforts**

Emergency support must be paired with efforts to address long-term needs. Implementation should involve coordination with local efforts as a crucial first step. NGOs and CBOs should receive support to achieve a level of capacity that will maximize long-term effective and equitable distribution of material resources. This often includes

development of systems by the community to identify those most in need through representative and participatory methods. New, donor-driven activities should encourage rather than discourage local efforts and resources.

- **Involve Youth as Part of the Solution**

Involve adolescents as part of the solution; they are in a unique position to provide support to each other, to younger children, and to those who are ill as a result of HIV/AIDS. Programs should address the needs of children of all ages, including adolescents. Interventions should include emotional, economic, educational, and social support. Youth should be involved and consulted to the greatest extent possible in design and implementation.

- **Value Volunteer Support and Build Capacity for Volunteerism**

Volunteers are at the core of the community response to vulnerable children. It is mostly female volunteers who manage the day-to-day supervision of support activities; identify, assess, and try to meet the needs of vulnerable children; and, counsel families in distress. In order to support and strengthen community responses, it is important to consider how best to support the volunteers who are the essence of these responses.

- **Foster Linkage Between Home-based Care and Support to Children/Youth**

Programs that target children affected by HIV/AIDS are often undertaken in isolation from programs that provide care to people living with AIDS. Integrated programming more effectively responds to the reality that the vulnerability of children in AIDS-affected households begins long before the death of a child's parent(s). Models for linking the two related types of activities include: (1) Programs that integrate activities focusing on care and support for people living with HIV/AIDS and those that focus on the needs of children and youth who are affected by the disease into a single intervention; and (2) Programs that remain separate but link related interventions to maximize coordination and complementary efforts.

- **Link Prevention with Support to Children Affected by HIV/AIDS**

It is imperative that care and support activities for children and their families link prevention and mitigation efforts. Recognition of the extremely high prevalence of HIV/AIDS in Zimbabwe continues to rise, as does the recognition of the need for support of children affected by the disease. Both prevention of further spread of the disease and mitigation of its effects must be supported with the limited resources available for HIV/AIDS–related efforts. Models are needed for the most effective ways to integrate these activities to maximize impact on both prevention and mitigation.

- **Emphasize Community Care**

There are a wide variety of reasons to support home-based options as an alternative to institutional care in Zimbabwe. Traditionally, orphans in Africa have been cared for by the kinship-based family system. The policy focus in Zimbabwe regarding care and support of children affected by HIV/AIDS emphasizes community care, with priority given to care within the extended family.

- **Integrate with Related Activities in Other Development Sectors**

In many regions of Zimbabwe, there are opportunities to integrate with activities initiated in other sectors that mobilize communities around issues such as health, development, and water sanitation. Empowered communities can identify priority problems for the community and develop, contribute to, and pursue sustainable solutions to those problems.

- **Support Monitoring and Evaluation (M&E) for Quality Programming**

Develop and implement plans for M&E as part of programs that address the needs of children affected by AIDS. The primary aim of M&E should be to enhance the effectiveness of an organization and its activities. Collected data should be shared/analyzed by program administrators and participants (including volunteers and the community) to improve planning and implementation, as well as to meet reporting requirements.

- **Develop Better Practices and Lessons Learned**

The GOZ, communities, donors, religious groups, and NGOs are attempting to meet the needs of vulnerable children through a variety of approaches, including community mobilization, microenterprise, community-based support, material assistance, counseling, and residential care. It is important to evaluate initiatives in a systematic manner and to share findings to help guide the implementation of similar activities.

Future efforts to use those resources wisely to care for the most children in the best way should:

- include systematic efforts for monitoring, evaluation, and research in lessons learned and

- apply much greater effort to identifying the types of approaches that are most effective, most sustainable, and least costly—in social and financial terms—and under which conditions they are most appropriate.

- **Link Economic Opportunity Intervention to HIV/AIDS Mitigation**

A family's ability to cope with the impact of HIV/AIDS, which may include the loss of productive labor, medical expenses, and absorbing orphaned children into the household, depends a great deal on the state of the household's economic resources before, during, and

after the disease affects it. Potential ways for microfinance, income-generating activities (IGAs), and/or skills development to mitigate the effects of HIV/AIDS include providing opportunities to increase savings and resources before crises occur, and maintaining or increasing small but steady income flows to poor households.

Strengthening the economic capacity of the community safety net is predicted to have increased impact on mitigating the effects of HIV/AIDS when coupled with community mobilization efforts. Communities that have participated in mobilization around the issue of children affected by HIV/AIDS will be more likely to have developed systems for identification of vulnerable children and actions needed to address this population.

RECOMMENDATION FOR NATIONAL ASSESSMENT

This paper recommends a national assessment on children affected by HIV/AIDS in Zimbabwe to provide further information on many important issues and build consensus among donors regarding program priorities. It is vital that donors coordinate their efforts to avoid a fragmented national response to this impending national calamity. Please see the full text for specific guidance on the components of a national assessment.

I. PURPOSE OF BACKGROUND PAPER

USAID/Zimbabwe commissioned this background paper on children affected by HIV/AIDS. Research and interviews were conducted in January and February 2000. The paper serves two basic purposes. First, as originally intended, it provides a foundation for USAID actions to enhance capacity at the regional and local levels, leading to possible interventions by USAID, such as increased support for community responses to children and families affected by the epidemic.

It should be noted that the scope of this paper is narrow. It focuses primarily on children affected by HIV/AIDS and is not intended to address all of the many efforts to fight HIV/AIDS in Zimbabwe by government agencies, donors, and other actors, nor should it be construed as doing so.

Second, pending the availability of a true nationwide analysis of HIV/AIDS interventions, this paper also serves to highlight unanswered questions about the impact of HIV/AIDS on Zimbabwean children. Examples include questions such as how the government of Zimbabwe (GOZ), donors, and others can coordinate and communicate about their efforts to mitigate the impact in children. For this reason, this paper is intended to be shared with government, donors, and other actors in the fight against HIV/AIDS.

USAID wishes to encourage rapid completion and circulation of a nationwide analysis. Readers of this paper should be advised that it is not intended as a replacement or substitute for a nationwide analysis. Given the extent of the epidemic, a comprehensive examination is urgently needed to inform decision-making and ensure effective, efficient use of resources.

II. BACKGROUND

THE SITUATION OF CHILDREN IN ZIMBABWE

During the first decade after Zimbabwe gained its independence in 1980, the country made great strides in extending a wide range of services to the majority of its people. Rapid expansion was needed to redress past inequities, which had rendered most Zimbabweans landless and without access to services such as health, education, safe drinking water, and adequate sanitation. Early child health care, maternal health care, and immunization played a beneficial role in dramatically improving the health and well being of children in Zimbabwe.

In recent years, Zimbabwe has experienced declines in many of the social indicators that made the country the showpiece of sub-Saharan Africa in the 1980's. Infant, child, and maternal mortality are all rising, and primary school completion rates are falling. The causes of the changes witnessed in the last few years are multiple and complex. No single factor can be blamed for the myriad challenges faced by Zimbabwe.

The HIV/AIDS epidemic has contributed to these reverses over the last few years through increased mortality, increased health care costs at the macro level, and reduction in household income and savings at the micro level. Real per capita spending by government on health, basic education, agriculture, and social welfare have all fallen substantially. Government budgetary deficits and resultant high inflation have had adverse effects upon the economy. Though up-to-date figures are not available, the deterioration of the economy, user fees, and other adverse factors appear to have had a major impact on children's access to health care and education.

The situation of children is determined to a large degree by their gender and where they live in Zimbabwe. The table below provides a profile of important aspects of the environment and access to social services, especially health care and education, of children and families in the four main socioeconomic settings within Zimbabwe. It focuses on girls since they are more likely than boys to be neglected or exploited.

	Communal Area	**Commercial Farm**	**Urban, High-Density**	**Urban, Low-Density**
Population	50%	20%	27%	3%
Primary Education	Community-built school with many untrained teachers and limited facilities	Farm school with many untrained teachers and limited facilities	Government school with some facilities and mostly trained staff	Government or private school with excellent facilities and trained staff
Secondary Education	About a 50% chance that she will attend secondary school but is unlikely to finish	Will probably not attend secondary school or will have to move to another area to attend	Good chance of attending secondary school but unlikely to go further than O level	Good chance of finishing A level
Household Chores/ Child Labor	Fetching water and firewood; cleaning house and utensils; helping with cooking; child rearing; agricultural chores	Fetching water and firewood; cleaning house and utensils; helping with cooking; child rearing; agricultural chores	Cleaning house and utensils; helping with cooking; child rearing; IGAs (e.g., vending, knitting, sewing)	Minor household chores; most chores done by domestic staff
Marriage/ Family Life	Possible early marriage and probable early pregnancy; husband may be migrant worker, polygamous. Will likely bear at least six children.	Possible early marriage and probable early pregnancy. Will likely bear at least six children.	Possible early marriage and quite likely to be a single parent. Will likely bear at least four children.	Will probably marry only after finishing post-secondary education. Will likely bear three children or fewer.
Inheritance	Husband is unlikely to leave a written will; at risk of losing assets if husband dies first	Husband is unlikely to leave a written will; at risk of losing assets if husband dies first	Husband may leave a written will. He may have life insurance or pension if he was in formal sector employment	Husband likely to leave a written will. He likely has life insurance or a pension. Good security.

Approximately 80 percent of women and more than 90 percent of men are literate in Zimbabwe. Eighty-five percent of school-aged children are in primary school, and 88

percent reach grade 7. After grade 7 enrollments decline rapidly with girls dropping out at a higher rate than boys. Fewer than 3 percent of students complete secondary school, of which only 40 percent are female.

School fees are set by communities and vary greatly. The European Commission (EC) estimates average fees in government schools at Z$113.25 for primary school, and Z$1978.48 for secondary school. Additional obstacles to school participation of low-income children include additional costs to cover items such as uniforms; childcare responsibilities; household chores; and transportation to and from school in rural areas.

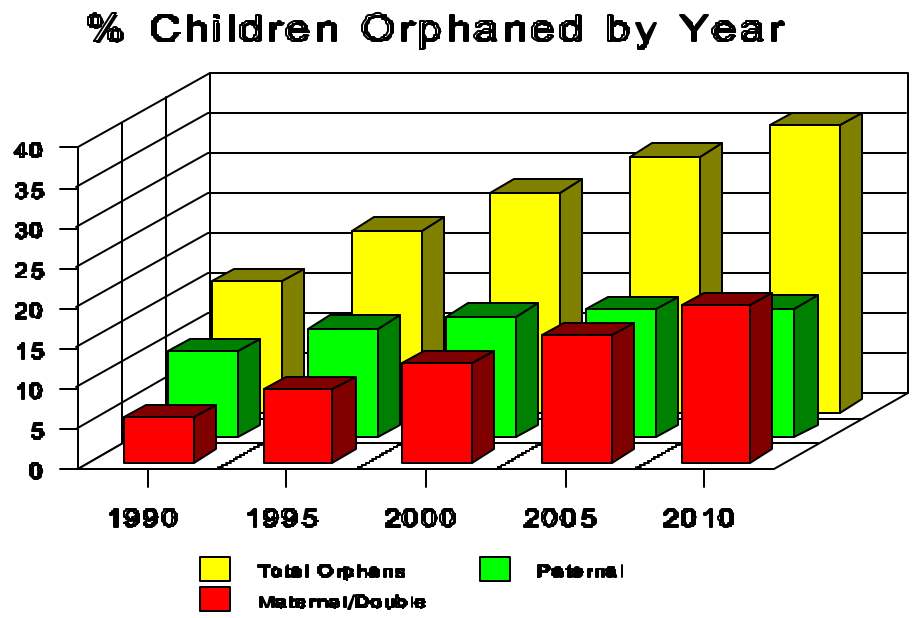
The education system is struggling. The GOZ, given the current economic crisis, has virtually no budget for schools' recurrent costs besides teachers' salaries. Many teachers are dying of AIDS each year. SIDA is currently conducting a study of the impact of AIDS on education.

Despite great progress in education, gender and "generational effects" are still key determinants of life courses in Zimbabwe. The judicial system in Zimbabwe typically is not progressive in its application of the law, and under customary law, men are titleholders of land, possessions, and children. Male privilege and female disempowerment characterize much of social and economic interaction. Men typically earn twice what women earn and control allocation of household resources. Females spend 7 hours per day on unpaid household-related work, while males spend only 40 minutes. Almost all of the caregivers and volunteers for PLWHAs are women and girls.

CHILDREN AFFECTED BY HIV/AIDS IN ZIMBABWE

Orphan Data: General estimates of the number of children orphaned as a result of AIDS have been developed using mathematical models and suggest an impending calamity. The NACP estimates that by the year 2000 in Zimbabwe, 670,000 children (1 in 6 children under 18) will be maternal or double orphans due to AIDS, peaking at 1.1 million by 2005 (33 percent of children under 15).

The chart below shows the mushrooming of the orphan population, which will occur in the next ten years as a result of the still expanding HIV epidemic in Zimbabwe. Recent data on fertility reductions in HIV-positive women suggest that these numbers may need to be revised downwards. However, data demonstrating HIV infection rates 30 percent higher in Zimbabwean women, as compared with men, suggest that maternal orphan estimates may be even higher than previously projected.



Data Quality and Definitions: Data derived from national enumeration or census collection is generally not considered adequate or accurate for analyzing the needs of children affected by HIV/AIDS. Nor is current data sufficient for planning and carrying out truly effective and efficient interventions. There is a critical need for a nationwide assessment to collect and share good quality data with concerned organizations as soon as possible.

Caution is in order. Uganda and Malawi both undertook national orphan registration in the early 1990's. Both reported that their experience was not successful. These efforts raised false expectations of assistance, produced unreliable figures, and highlighted the lack of ability to maintain or update registers. Both countries terminated their efforts and now recommend ongoing registration in small pilot areas linked to local groups and specific assistance programs.

Another question concerns the definition of the term "orphan." Although in recent years the term has been used most commonly to describe a child who has lost both parents, throughout Western history and in most developing countries, an orphan is a child who has lost one or both parents. Children may be maternal, paternal, or double orphans who have lost both mother and father. Definitions of orphans that exclude paternal orphans underestimate total orphan numbers by 45-70 percent. Definitions of orphans that exclude children 15-17 years old underestimate total orphan numbers by 30 percent. Prior to the HIV/AIDS epidemic, approximately 7 percent of all children in Zimbabwe were orphans; 60 percent were paternal orphans, most with fathers dying from age-related diseases. Less than one third of orphans were maternal orphans. Double orphans represented approximately 7 percent of total orphans and less than 0.5 percent of all children.

Who are the children affected by HIV/AIDS? What are the effects of the disease on children?

While there is an urgent need for more current, precise data, the effects of HIV/AIDS on children can be described in broad terms for discussion purposes. For planning purposes, it is still critical to collect and analyze the necessary data and to disseminate it appropriately.

The HIV/AIDS epidemic is leaving increasing numbers of vulnerable children in need of special care and protection. (For discussion purposes, a child is a person under 18 years old, and a young child is a person under 5 years.) Children are affected by AIDS in many ways, from the burdens of caring for sick parents and younger siblings, to the absence of a mother who is caring for a family member in another household, to the loss of income and work as adults become ill or die, to the loss of capital expended on medications and funerals.

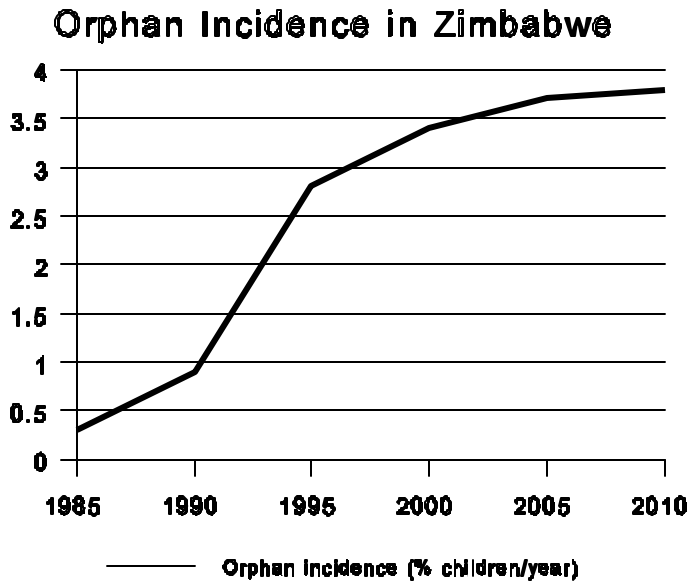
Terminology: Differences of terminology exist. Children in Especially Difficult Circumstances (CEDC) is an inclusive term for all vulnerable children including orphans and other children affected by AIDS. The term Orphans and Vulnerable Children (OVC) has been used to focus attention on the increasing numbers of orphans as a result of the AIDS epidemic. However, the term used in this document to refer to children of the HIV/AIDS epidemic and other vulnerable children is Children Affected by HIV/AIDS. Children are affected by HIV/AIDS before their parents die. Use of this term draws attention to the need to respond to these children before they become orphans. It is important to note that not all orphans are vulnerable.

Effects on Children: When a parent develops AIDS-related symptoms, children often shoulder new responsibilities, such as domestic, income-generating, and childcare responsibilities, and caregiving activities such as feeding, bathing, toileting, giving medication, and accompanying relatives to clinic or hospital for treatment. When a parent is ill, children's school attendance drops because their labor is needed to pay family and medical expenses or because families cannot afford to pay school fees. In addition, the psychological effect on children who are living with dying parents, often in extremely cramped and impoverished households, is vast and generally remains insufficiently addressed.

Other children who are vulnerable yet are not directly affected by HIV/AIDS might be included within the category of children affected by HIV/AIDS. Children may experience reduction in their quality of life due to transfers of money to other relatives affected by AIDS or because their mother goes to live with a sick relative to provide home care. Children may see their standard of living deteriorate due to economic constraints following the death of an aunt, for example, when cousins come to live with them in their new foster family.

In countries with severe HIV/AIDS epidemics such as Zimbabwe, no family has escaped the impact of AIDS. As a result, the situation of other vulnerable children, including the

disabled, the destitute, and child laborers, has worsened. The table below (after Hunter, S.) provides a conceptual framework of orphans' and other children's vulnerability.



Children under 5 are particularly vulnerable if their mother is sick or has died, especially if they are in the care of an elderly or adolescent caregiver. Large numbers of orphans live with elderly guardians, many of whom have become dependent upon the children in their care. Increasingly, orphans are taken to live in families with large numbers of other children, sometimes consisting of orphans from two or three families. Since disability is common within the community, the added disadvantage of orphanhood means that orphans with disabilities are particularly vulnerable.

In addition, children are vulnerable because they live with a sick guardian, usually a parent dying of AIDS. Zimbabwe has more than 100,000 adult deaths per annum due to AIDS. It is likely that at least 200,000 children per annum experience the death of a parent. In addition, large numbers of children who are not orphans are vulnerable because they live in female-headed households (>30 percent in Zimbabwe) or in extremely poor households (91 percent of the population on communal lands were reported by a 1995 Poverty Survey to be “poor” or “very poor”).

Institutional Care and Street Children: In 1997, 1,753 children lived in 39 institutions (children’s homes or orphanages) in Zimbabwe. Less than 50 percent of them were orphans, compared with an estimated 1.2 million paternal and maternal orphans under 15 from all causes throughout Zimbabwe. In Harare, there were an estimated 1500 street children, 67 percent of whom were on the streets each day to beg and work, while 33 percent were off the street, with little contact with their families. About one half as many were estimated to be street children outside Harare.

III. CARING FOR CHILDREN AFFECTED BY HIV/AIDS

THE FAMILY IN ZIMBABWE

A good deal is known about the role of the nuclear and extended family in Zimbabwean culture, particularly as it relates to care of sick family members and of children. However, much more study is needed to clearly understand the situation of children affected by HIV/AIDS.

The impact of AIDS deaths on households is unlike other disasters, such as drought and famine, due to the incremental nature of the epidemic. AIDS wears down extended families' resources over a period of several years at the same time that the number of orphans continues to increase. The extended family is not a social sponge with an infinite capacity to soak up orphans. Blanket statements about the role of the extended family in Africa as a safety net and assumptions that relatives will be ready and able to assist members in need should be treated with caution.

Children who slip through traditional safety nets are especially vulnerable to social, economic, and psychological effects and to increased susceptibility to HIV infection. It is essential to understand extended family safety net mechanisms so that proposed orphan initiatives support rather than undermine traditional orphan care.

The Effect of Changing Traditions and AIDS on Marriage, Widows, and Orphans

Much is known about the topics of marriage and brideprice in Zimbabwean culture. These topics also influence and relate to the status of women, who are the primary caregivers for sick family members and children. However, much more study is needed to understand less obvious interrelationships and dynamics between these topics and the AIDS epidemic. Does HIV/AIDS affect marriage and brideprice customs? How do marriage and brideprice relate to the situation of children affected by HIV//AIDS (both positively and negatively)?

Traditionally, marriage was not so much the linking together of two individuals but of two families. When marriage was decided upon, a brideprice in the form of a number of cattle was paid to the bride's family; the payment of brideprice led to future children becoming the responsibility not only of the father but of his family as well. Traditionally, the concept of a "social" orphan did not exist in Zimbabwean societies.

Orphaned children were cared for by members of their extended family, especially by paternal aunts and uncles who took on the caregiving functions of parents. The extended family was the traditional social security system and its members were responsible for the protection of the vulnerable, care for the poor and sick, and the transmission of traditional social values and education.

In recent years, changes such as increased labor migration, the rise of a cash economy, demographic change, availability of formal education, and Westernization have weakened extended families. Labor migration and urbanization have led to a reduction in the frequency of contact with relatives and encouraged social and economic independence; possessions are perceived as personal property and no longer belong to the extended family.

Increased life expectancy and family size mean it is now impossible for an extended family of three or four generations to reside together. The diminishing availability of land makes it difficult for large families to be economically independent through subsistence agriculture. Education about social values occurs through schools and interactions of children with their peers rather than through traditional mechanisms, which has lessened the ability of older people to exert social control over children.

Some traditional roles of the extended family have been modified while others have almost disappeared. In many traditional African communities, widows are inherited through remarriage to the brother of the deceased husband, with property being inherited by paternal relatives. In Zimbabwe, the practice of widow inheritance is declining and many women now refuse traditional remarriage. In a traditional community in rural Zimbabwe, only 30 percent of respondents believed wife inheritance was still practiced with 94 percent believing it to be a bad practice. However, widow inheritance may have been replaced by a practice whereby male relatives maintain sexual access to widows without formally inheriting them.

In one study, 76 percent of families' property was reportedly inherited by the children, while only 15 percent of families stated that relatives had taken property, suggesting that the well-publicized practice of “property-grabbing” was not widespread.

Brideprice is still commonly practiced, though it now often consists of a cash payment earned by the husband-to-be, rather than cattle and other possessions raised by members of his extended family. Thus marriage itself has become more a contract between two individuals, leading to weaker linkages between and within extended families.

Traditionally, fostering of orphans in patriarchal societies rested with paternal relatives. In practice, considerable flexibility exists in many marriage systems. A man may agree to the marriage of his daughter based on the promise of payment of the brideprice. If the husband dies before making these payments, his lineage will have no claim to the children of the marriage and conversely, no responsibility to care for paternal orphans.

Change in the traditional practice of orphan inheritance to paternal relatives may be due to both a weakening of traditions, such as payment of brideprice, and also to increased numbers of orphans overwhelming the capacity of paternal relatives to provide care.

CURRENT STATE OF FAMILY AND COMMUNITY RESPONSES

Studies exist on the current state of family and community responses to HIV/AIDS generally in Zimbabwe. More study is needed to understand more clearly the interrelationships and dynamics between family and community response, and the effects of the AIDS epidemic on children. What types of family and community response exist? Which ones are effective? What types of assistance from the government, donors, USAID, and others are needed?

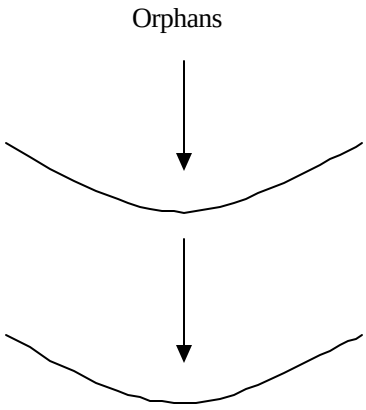
One important question in Zimbabwe is at what point of family burden do extended kinship networks abandon responsibility for orphaned children? A 1997 study found that the decision to leave children in child-headed households in Zimbabwe was often made by relatives who were reluctant to foster older children in their own families. Child-headed households were more likely to be established if a teenage child experienced in childcare was available to head the household and if a relative lived nearby who could provide supervision - a so-called "supported child-headed household."

Frequency of existing contact with members of the extended family may be one measure by which to gauge the likelihood that children might be abandoned if they become orphans. A major concern with regard to orphan care among the nearly 2 million people living in commercial farm communities in Zimbabwe is that many families do not have access to the traditional extended family system. A study of 449 households of commercial farm workers in Zimbabwe found that 73 percent of Zimbabweans had regular contact with relatives, while 27 percent had irregular or no contact. Among the 160 households who were Malawian or Mozambican immigrants, the rates were 38 percent and 62 percent, respectively.

It is important to monitor the capacity of extended families to care for orphans. It is particularly important that the nationwide assessment help identify areas with critical masses of orphans and children affected by HIV/AIDS. In severely affected communities, an increase in the number of orphans is inevitable as a consequence of an increase in parental mortality rate. However, increasing numbers of orphans only become a major concern when the numbers of children living in especially difficult circumstances increase. Children who slip through the safety net may end up in a variety of vulnerable situations, as identified in the figure below (Foster, 2000).

The prevalence of child-headed households in a study in the Mutare area in 1998 found 4/1000 such households in Zimbabwe. Other indicators of stress on the extended family coping mechanism include increased numbers of children removed from schooling to be involved in care and a rise in the number of orphaned street children.

Model of the Extended Family Safety Net for Orphans in Africa



Traditional Safety Net:
Aunts and Uncles

Alternate Safety Net:
Grandparents and Other Relatives

Child-headed Households

Street Children

Domestic Workers or Other Work

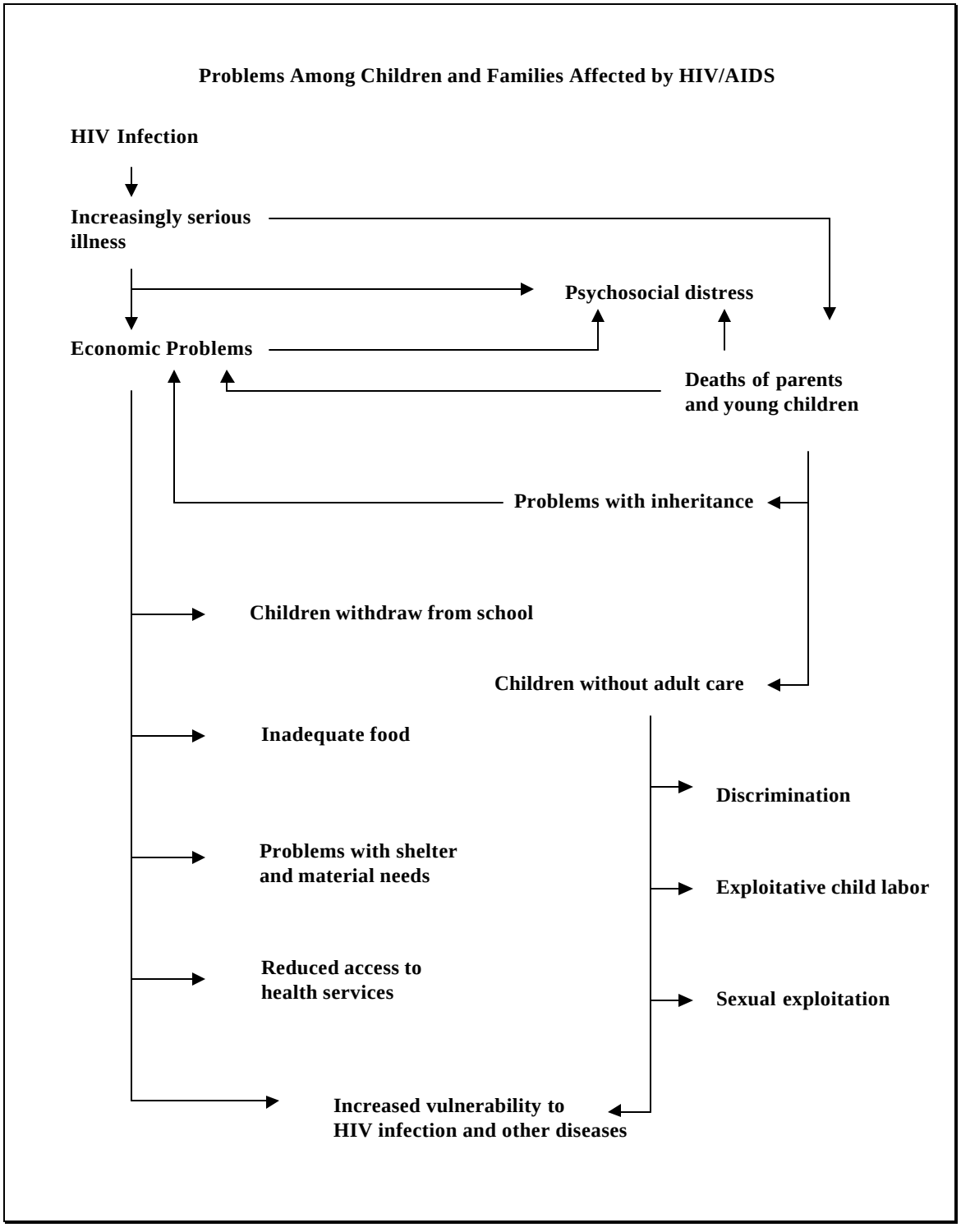
Children Who Slip Through the Safety Net

IV. THE IMPACT OF HIV/AIDS ON CHILDREN, FAMILIES, AND COMMUNITIES

A CONCEPTUAL FRAMEWORK IDENTIFYING AREAS OF VULNERABILITY

Children affected by HIV/AIDS share many problems with other children in especially difficult circumstances. Other children also lack school fees, food, blankets, and clothing and experience discrimination due to poverty. Other children are also vulnerable to physical abuse, sexual exploitation, and child labor. However, qualitatively, social and psychological morbidity of children affected by HIV/AIDS may be intense after the prolonged illness of one or both parents and the sequelae that befall these children after they become orphans.

Quantitatively, as the number of children without parents continues to grow, traditional extended family support structures are becoming saturated and their ability to function is threatened. Children who slip through the extended family safety net are likely to become street children, child laborers, or become HIV-infected through exploitation, early marriage with older men, or the exchange of sex for money or other material support. The framework below, developed by John Williamson, suggests the progression and relationship of problems experienced by HIV/AIDS-affected parents and children. A discussion of the consequences follows.


Problems Among Children and Families Affected by HIV/AIDS
HIV Infection
Increasingly serious illness
Psychosocial distress
Economic Problems
Deaths of parents and young children
Problems with inheritance
Children withdraw from school
Children without adult care
Inadequate food
Discrimination
Problems with shelter and material needs
Exploitative child labor
Reduced access to health services
Sexual exploitation
Increased vulnerability to HIV infection and other diseases

SOCIOECONOMIC IMPACT: EFFECTS ON INCOME, ASSETS, AND FAMILY MEMBER WORKLOADS

Relatively little is known in Zimbabwe about the effects of HIV/AIDS on family income, assets, and the distribution of workloads among family members, including children. These are critical topics to be addressed by the nationwide assessment, for planning purposes. The general dynamics are described from existing research, but more study is urgently needed.

In severely affected communities, HIV/AIDS has an impact on children, families, and communities that is incremental. Continuous deaths among young adults lead to social and economic effects that increase with the severity and duration of the epidemic. The impact of HIV/AIDS on children and families is compounded by the fact that many families live in communities that are already disadvantaged by poverty, poor infrastructure, and limited access to basic services.

Private transfers of assets within families and communities are traditional mechanisms for alleviating distress. One way to gauge the strength of community-coping mechanisms in the face of the impact of AIDS is to measure the strength of community responses.

This community safety net is being weakened as a result of the incremental impact of the AIDS epidemic on severely affected communities. Better off families find their economic reserves depleted due to continual demand from relatives affected by AIDS; they are less able to contribute in cash, kind, or the provision of work to friends and neighbors in need. As the number of families falling from poverty into destitution increases as a result of AIDS, the amount of relief that can be provided per destitute family by philanthropic individuals and community groups decreases.

The care of children affected by HIV/AIDS in developing countries is falling on poorer people within communities, especially women. The death of a father within a household often has deleterious economic and social consequences for children. Expenditures for treatment of fathers with AIDS and their funerals have been higher than for mothers. Loss of the father's income and property inheritance by paternal brothers leads to widows' impoverishment and deleterious effects upon orphaned children.

In a survey of 211 orphan families in a remote rural area of Zimbabwe, 96 percent of families were headed by females, 89 percent of families relied on women as the breadwinner, and only 3 percent of orphan households had a member who was a breadwinner in employment. Abject poverty was seen in children in Zimbabwe living in child- and adolescent-headed households where average monthly incomes were $8 compared to $21 among non-orphan neighbors.

In child- and adolescent-headed households, only 16/30 households with known relatives received visits more than once per month, while 14/30 received material support from relatives in the preceding year. In another study in Zimbabwe, heads of rural orphan households were likely to receive wage remittances and were more reliant on the sale of

agricultural produce and sale of services, including prostitution, than were non-orphan households.

In desperate circumstances, when there are no other sources of income, poor households may sell off assets to provide desperately needed revenue. In a study in Zimbabwe, 7/40 orphans reported that livestock, which are a form of saving, had been sold to raise money for food or school fees. Selling assets, such as oxen that provide draught power, meets immediate needs at the cost of undermining long-term development.

One of the less obvious economic effects of the epidemic is an increase in the amount of work performed both within and outside the household by working children. The workload of children affected by HIV/AIDS, which starts when parents become sick, often increases when children become orphaned, and may be greater than for non-orphans living in the same household. Orphans have responsibility for supervising younger siblings; doing domestic chores such as cooking, cleaning, carrying water, and laundry; and helping with agricultural or income-generating activities. To generate income, adolescents may leave orphan households to work as agricultural laborers for farmers or as domestic laborers in towns.

Increased domestic workload is often disproportionately greater for girls than boys. Some girls exchange sex for money or other resources, or enter into marriage as girl brides in order to provide for the needs of younger children in their household.

RELOCATION AND SEPARATION: FAMILY MEMBER IN-MIGRATION AND OUT-MIGRATION

Relatively little is known in Zimbabwe about the effects of HIV/AIDS on family member in-migration and out-migration, including children. These are critical topics to be addressed by the nationwide assessment, for purposes of program planning and implementation. General dynamics are described below from existing research.

Changes in the composition of households through in- and out-migration of family members are an important mechanism by which extended families cope with the impact of HIV/AIDS. In a study in Zimbabwe, 17 percent of orphans were reported to have moved to another relative's home, often some time after the death of a parent. Rates of relocation are particularly high among double orphans. In another study, 33 percent of children in child-headed households, most of whom were double orphans, relocated during the preceding two years. Urban-rural relocation often occurs with the onset of serious illness.

Rural-urban migration of adults, resulting from the impact of HIV/AIDS, occurs when widows migrate to towns in search of work or partners. Migration of orphans appears to be predominantly intra-urban and intra-rural with smaller urban-rural flows. This may lead to clustering of orphans in poor areas. One study found that, out of 61 orphan families, none relocated from urban to rural locations, and 5/44 orphan families relocated from rural to urban households. In addition, parental migratory patterns in Zimbabwe often leave young people without adequate adult supervision and guidance in sexual matters.

Mobility is particularly common among adolescents affected by HIV/AIDS. For example, non-resident young relatives may become caregivers in urban households to ensure resident children continue their education.

Separation of siblings following the death of a parent is a fairly common coping mechanism to share the economic burden of care between several relatives. Children, especially those under 5, may be fostered, leaving siblings living by themselves. Adolescent girls may be "pawned," or sent to a relative or neighbor to work in return for money paid to the fostering family. Few households find the idea of separating orphaned siblings from one another desirable - a practice that is associated with increased psychological distress.

EDUCATION

Schooling breaks the intergenerational cycle of HIV. Its value is twofold, as an investment in HIV prevention and as an investment in a productive future for children, their communities, and their nation.

Few data have been collected on the effects of HIV/AIDS on school enrollment, absenteeism, achievement, dropout, repetition, and completion rates in Zimbabwe. Analysis of data on the Zimbabwean education system and interviews with community members, teachers, students, and out-of-school youth, and Ministry of Education, DSW, NGO, and donor personnel all suggest that the effects of HIV/AIDS exacerbate existing inequalities in education.

Caregiving, household chores, and lack of autonomy may interfere with the school attendance of children affected by HIV/AIDS. Lack of money may preclude payment of school fees. Heavy responsibilities, grief, exploitation, and lack of time are just a few of the factors that undermine a child's ability to achieve in school.

Schooling is recognized by communities and educators in Zimbabwe as a strategic approach to HIV prevention. Particular emphasis is placed on the power of school to protect girls. The protective significance of formal schooling, especially for girls, is likely linked with later age of sexual initiation, a decrease in early marriage, a positive outlook on the future, better access to information and services, and a stronger sense of self efficacy.

A better understanding of how and why schooling reduces risky sexual behavior is needed to strengthen the features of education that have the greatest impact on the reproductive health of girls and children affected by HIV/AIDS.

Children affected by HIV/AIDS are at high risk of infection; thus, schooling is particularly important for them. However, enrollments, attendance, and achievement of children affected by AIDS are believed to be lower than those of other children. Interviews with community members, teachers, and district ministry personnel during field visits in

January 2000 indicated that girls are drawn out of school to care for sick parents and/or younger siblings.

Increasing enrollments of underage children in first grade suggest that child-to-child care responsibilities may be increasing. Children affected by AIDS who remain in school often do poorly because they have little time for schoolwork and little support at home. Poor nutrition or irregular meal patterns in households under stress also may reduce academic performance. Teachers and community members express concern over the psychosocial effects of HIV/AIDS on these children, concluding that psychosocial distress contributes to a pattern whereby children affected by AIDS in general do worse in school than other children.

Although central government school fees at the primary level have been abolished, children still pay local school levies. Other school-related expenses are significant; school uniforms are often cited as an overwhelming expense. Law in Zimbabwean schools requires uniforms, and children not properly clothed face stigmatization. Children affected by AIDS are likely to be particularly disadvantaged by these educational costs. Family and extended family members are more likely to spend limited resources on boys than on girls and on their own children rather than on fostered children if choices have to be made. USAID, the GOZ, and other donors may want to consider interventions to support education.

Fees rise sharply (17 fold) when children pass from primary to secondary school. As they enter the years when they are most vulnerable to HIV infection, girls and children affected by AIDS are most likely to leave school. What interventions might encourage girls to stay?

It would be helpful to examine why schools do relatively little to educate children about HIV/AIDS despite the fact that Zimbabwe has a strong HIV/AIDS curriculum. For example, are teachers trained and encouraged to use it? Girls are six times as likely to be infected with HIV during their school years than boys, but girls have less knowledge than boys about HIV transmission and how to protect themselves. The omission of AIDS education in the schools is therefore particularly significant for girls. For male and female children affected by HIV/AIDS, implementation of the HIV/AIDS curriculum might mitigate the stigma some of them suffer via better information, discussion, and transparency about their circumstances and struggles.

HEALTH AND NUTRITION

Clearly, the obvious adverse effects of HIV/AIDS include an irreversible decline in general health and nutritional status. However, beyond the obvious and well-documented effects on PLWHAs, relatively little is known in Zimbabwe about the health and nutrition effects of HIV/AIDS on children. This is a critical topic to be addressed by the nationwide assessment. Some questions are suggested by existing research, but many others must be included as well.

For example, a close correlation has been reported between child morbidity and the quality of parenting. Will the health of orphans, especially those in the care of elderly and

adolescent caregivers, be worse than other children? Are substitute caregivers informed about good nutrition, oral rehydration treatment for diarrhea, and the recognition of serious illness? If not, what are the effects?

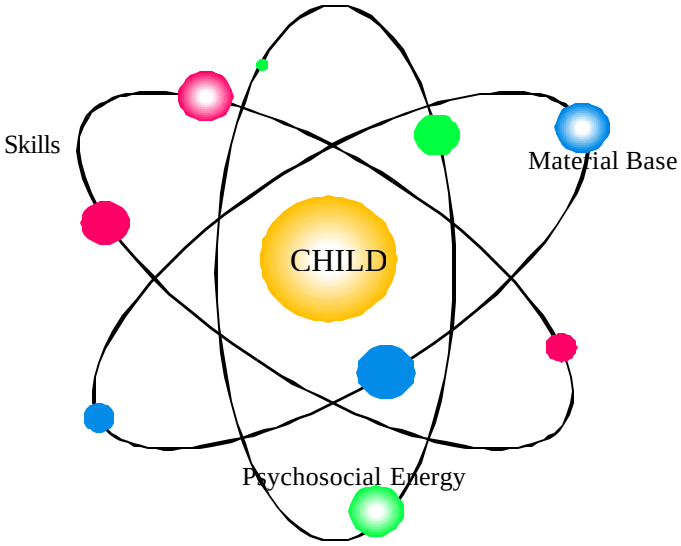
Might significant increases in malnutrition result from reduced household agricultural production? Unpublished data from Zimbabwe found that orphans were significantly more likely to have fewer than three meals per day, compared with their non-orphan counterparts (67 percent, 124/186 versus 34 percent, 310/923). In children under 5, there was no greater wasting among orphans when compared to non-orphans. This study, however, did not exclude possible bias because of increased likelihood of HIV infection in orphans. More study is needed on these topics.

PSYCHOSOCIAL IMPACT

In developing countries such as Zimbabwe, in spite of attention to the predominant impact of HIV/AIDS on children's physical, social, and economic needs, little study has been done on the psychological and emotional impact on children. The national assessment should include psychosocial effects to facilitate design of interventions to prevent, mitigate, and/or treat emotional distress.

It is understandable to concentrate on immediate, basic needs that are not met. It is difficult for agencies to concentrate on addressing less immediate or obvious psychological needs. Yet, the emotional impact of AIDS on children in developing countries is essentially no different from developed countries, with many or most children showing psychological reactions to parental illness and death. Stigmatization, dropping out of school, changing friends, increased workload, discrimination, and social isolation of orphans all increase stress and the trauma of parental death.

Approaches in support of children affected by AIDS need to be holistic, taking into consideration that all aspects of a child's life are under stress due to the situation in which they are living. The following graph shows the key areas to consider when focusing on holistic programming.



Graph: Holistic Model of Support

The need to address all three components holistically for optimal development is illustrated by Humuliza (1999):

- material base (tools (stove), raw-material, e.g., maize meal)
- skills (e.g., need to know how to cook maize meal, or there will be no food)
- psychosocial energy (e.g., if I have maize meal and know how to cook, but I am too depressed and feel life makes no sense, then we will have no food)

In many support programs the prime focus is on addressing the material needs of orphans. Again, while understandable, an exclusive focus on material needs misses key elements.

It is important to assess how many programs address the needs for skill transfer to children affected by AIDS toward sustainable self-help. This will point the way for the GOZ, USAID, and other donors to consider appropriate, sustainable responses.

The psychosocial effect, though not as directly visible, is often neglected and considered to be merely a transitional stage that will pass after some time. Adults often lack the understanding of children, and children are sometimes unable to express their grief in a form that adults can understand. Assessment is needed of the ongoing need for support for grieving children.

The World Health Organization (WHO) has developed a crosscultural standardized psychometric tool to measure quality of life. The main domains included in this assessment are following:

- physical well being
- psychological well being
- level of independence
- social relationships
- environment
- spirituality/religion/personal beliefs

This test has not yet been adapted and utilized with children or adolescents but does have the potential to eventually be used to assess the effect of interventions related to the well being of children affected by HIV/AIDS.

VULNERABILITY OF CHILDREN TO ABUSE AND HIV INFECTION

The immediate and grave effects of HIV/AIDS infection on children may demand first priority, but the nationwide assessment must also address future implications in some depth. Thus, in addition to collection and analysis of data on the present situation, an analysis should include projections of various scenarios and how interventions might improve them.

Demographic change is already taking place as a result of HIV/AIDS. Notches are occurring in the population pyramid coinciding with the age groups of maximum AIDS impact, 20-35 years in women and 25-45 years in men. In future years, these notches will broaden and work their way up the pyramid. Lack of adult protection, together with other social, economic, and psychological effects of HIV/AIDS, will combine to increase the susceptibility of children affected by AIDS to HIV infection.

While the epidemic may not lead to a population decline, it will certainly alter dependency ratios and lead to a shortage of adult caregivers and laborers. This will have an impact on future generations of children, as yet unborn. In the absence of an effective vaccine or substantial behavior change, the numbers of orphans will continue to grow. The reduction in availability of adult caregivers, especially women, will lead to increased vulnerability of children affected by AIDS in the future.

Although there is a striking lack of data in Africa, the need for action is clear, given the prevalence and circumstances surrounding acquisition of HIV and other sexually transmitted infections in children affected by AIDS.

Reports in the Zimbabwe media of child sexual abuse are commonplace. Rape and sexual abuse of children appear to be increasing in communities affected by HIV/AIDS. Factors include predatory males seeking younger partners whom they believe to be less likely to be HIV-infected than older females; cultural practices that are used to justify male relatives having sex with adolescent females; and prescriptions by traditional healers that advise men to have sex with virgins as a cure for AIDS.

Psychological factors also increase children's vulnerability. Orphaned children are more likely to be depressed than non-orphans, and their experience of repeated bereavement, insecurity, material deprivation, abuse, neglect, and the stigma of AIDS may have serious intergenerational consequences. Orphaned teenagers may seek solace in sexual relationships as a substitute for parental love.

The specter of increased numbers of children growing up who are highly susceptible to HIV infection hangs over this generation: of hundreds of thousands of children living as street children or in destitute, child-headed households; of teenage orphan girls providing survival sex or favors in exchange for money or food; of children leaving school to work alongside adults in a neighbor's fields or leaving the family to work as a domestic; or of young, unsupervised children being abused or exploited.

Enhancing community responses to the situation of children affected by AIDS by encouraging supervisory visiting programs helps to strengthen community-wide child protection mechanisms. Assisting groups of women who work together to generate income support to destitute orphan households can provide teenage girls with an alternative to income derived from commercial sex. Enabling children, especially girls, to stay in school as long as possible is a means of protecting them from situations that make them vulnerable to HIV infection.

Perhaps nowhere is the imperative to link the provision of care and support activities to HIV prevention seen more clearly than with children affected by AIDS. Care programs are an ideal entry point for prevention programs and have the potential to be effective in preventing the future transmission of HIV.

When today's orphaned children and adolescents become ill with HIV infection, they will have no mother to return to in order for them to receive home care during their terminal illness. After today's orphaned children have grown up and had their own children, some of them will die of AIDS, leaving their children behind as "grand orphans," with no mother and no grandmother to care for them. Caring for children affected by AIDS today is a means of preventing these same children from becoming the victims of HIV infection tomorrow.

It is difficult to envision the possibility of protecting children affected by AIDS from exploitation and preventing them from becoming HIV-infected unless their basic needs are met. Strengthening the efforts of communities responding to children affected by AIDS is not only an investment in development, it is an investment in the prevention of future HIV infection, an investment in a shrinking HIV epidemic.

V. LOCAL RESPONSES TO CHILDREN AFFECTED BY HIV/AIDS

Need for Nationwide Analysis: As stated, this Background Paper has a narrow focus (Children Affected by HIV/AIDS). A complete nationwide assessment is needed to enable development in Zimbabwe of an effective, efficient, coordinated approach to HIV/AIDS program planning, implementation, and evaluation of efforts to address the needs of children affected by HIV/AIDS. The assessment would describe the epidemic's impact on children as well as the governmental and voluntary efforts to combat it. It would answer the following basic questions: What is being done? What works and what does not? Where are the greatest needs and weaknesses?

It would also give an overview of the following:

Coordinating Bodies (Governmental and Nongovernmental): The assessment would describe what coordination and communication mechanisms exist and indicate strengths and weaknesses. There should be some indication of the degree of organization, efficiency, and effectiveness. This could form the basis, as needed, for reorganization, innovation, mobilization, or other actions.

Comparative Advantages, Opportunities, Coverage, Unmet Needs, Gap Analysis: Other critical needs include determining answers to the following questions: Which organizations are best situated to perform which tasks? What are the strengths and weaknesses of NGOs, and community-based organizations? What is the most effective use of resources? Which parts of the country have the best coverage? Where and how should donors fund actions? What/where are the most critical unmet needs and service gaps?

Due to the critical need, USAID initiatives must proceed, even in the absence of a full and complete assessment. However, after a nationwide assessment, the USAID effort to address the effects of HIV/AIDS on children can be better situated in relation to the overall array of related activities. It can also then connect more effectively with other initiatives.

In advance of the assessment, there has been an impressive response by NGOs, churches, community groups, and parts of the private sector to the situation of children affected by AIDS. The next section describes examples and provides an analysis of such responses and considers key issues related to the provision of services.

CBOs WORKING WITH CHILDREN AFFECTED BY AIDS

The nationwide assessment should take a comprehensive look at the various roles, responsibilities, and capabilities of all types of organizations working with HIV/AIDS, with particular attention to community-based groups. The assessment would specify to the extent possible their service areas, populations served, services provided, capacity, and needs.

Available studies indicate growing recognition of the urgent need to strengthen spontaneous community-based initiatives such as caring for the sick and orphans. For definition purposes, community groups here include voluntary associations and community-based organizations that do not have part-time or full-time paid employees.

It is estimated that more than 100 such groups have been established in Zimbabwe in response the situation of children affected by AIDS. Community groups are working in rural, urban, and commercial farm sectors in Zimbabwe. Responses are focused on all orphans, not solely on children orphaned by AIDS. Support is normally provided to other vulnerable children, not simply to orphans. Most activities provide support to the wider community, not just to members of one church, group, or clan.

The types of community organizations that have established programs to support children affected by AIDS, and the ways in which programs were established, are diverse. Many are church groups, which already have a religious mandate and an existing interest in supporting widows and orphans. Exact coverage information is scarce.

Within the city of Mutare, a network of some 150 volunteers from 30 different churches have extended their home care activities and now regularly visit around 150 orphan families. According to the orphan program coordinator of the Evangelical Fellowship of

Zimbabwe (EFZ), a denomination with around 100,000 members, some 50 EFZ churches around Zimbabwe are operating approximately 20 orphan support programs. It is likely that some of the larger denominations have an even larger number of programs functioning out of their member churches. A broader assessment should specify coverage, gaps, needs.

Volunteers have established programs sometimes simply as a result of seeing the need in their community or hearing of a similar program elsewhere. NGOs and staff working with denominational umbrella body organizations such as EFZ or the United Methodist Church have assisted groups in establishing similar programs. A broader assessment should address issues such as program and staff quality.

Traditional leaders with an existing interest in providing for the poor in their communities have revived or extended traditional mechanisms of support for orphans, sometimes with help from the DSW and UNICEF. Some community groups have initially been involved in providing home care services and have extended these programs to provide visits and material support to households with orphans.

Of the 150 support groups for PLWHAs listed in the *Zimbabwe 1999 Directory*, 13 list orphan support as one of their activities; many PLWHA groups begin their activities by providing support to the families of the deceased, which later evolve into support programs for other children affected by AIDS. (Directories of this type might be expanded and institutionalized as a result of a larger assessment effort.)

The following are general examples of types of support provided by community-based initiatives (more precise information would be provided by a nationwide assessment):

Identifying and monitoring the most vulnerable children through household visiting: Many orphaned children live in impoverished or otherwise difficult circumstances. Although they may receive visits and material resources from members of their extended family, such support may be inadequate. Some community programs ask women volunteers to make a list of all orphans, other vulnerable children, and their caregivers in the surrounding area and prioritize those with greatest need. Volunteers visit households in their vicinity on a regular basis. Regular visits allow volunteers to monitor changing family situations, channel material support and training to households, and be available should the household require urgent assistance.

Program monitoring: The quality of information systems varies. Many community groups have set up basic data collection systems to monitor the functioning of their programs. Some systems are elaborate and support management decisions based on data.

Providing Care and Psychosocial Support: Volunteers are chosen because of their special concern for working with vulnerable children. Households containing children living alone, with elderly grandparents or with sick caregivers, are most likely to be selected to receive care. Visiting frequency is determined by the family's situation - those where children receive little or no material or emotional support receive top priority. Those with greatest need might be visited twice weekly or more often.

Volunteers strive to establish a rapport with children and their caregivers. The development of a strong, motherly bond with the children, or sisterly bond with the guardian, helps to provide a lifeline to families in need. When a crisis develops, vulnerable orphan households may turn to their "tete" (aunt).

Volunteers may provide training in hygiene, child care, and HIV/AIDS prevention. They may act as a liaison person with the local church, clinic, school, traditional leaders, police, or DSW when the family needs help. They may provide psychological and spiritual support to families affected by AIDS. Their presence within a community helps to minimize physical and sexual abuse; regular visiting can provide an early warning system for such cases.

Identifying and prioritizing vulnerable children provides a foundation for other activities that offer material support to individual families. Programs that fail to identify the most vulnerable households and families or channel material support to families that have few needs, are less effective and may undermine existing extended family and community coping mechanisms.

Supporting community coping mechanisms through material support: Community coping mechanisms exist within most traditional communities and can provide a safety net for community members in need. At such times, destitute families may receive support from others living within the community. Most community initiatives try to provide material support to households with the greatest needs. Volunteers find it difficult to visit destitute families without taking some item of food or other form of support. Most often, volunteers provide material support themselves. Other sources of support, which may be accessed by volunteers, include benevolent bodies such as local religious groups, sources of loans such as saving cooperatives, and individual benefactors.

Community-based orphan support initiatives have a demonstrable ability to target small amounts of material support to large numbers of orphan households in greatest need. Volunteers usually identify the households that are to receive assistance. Support may be provided for items such as school fees, food, clothing, blankets, or agricultural inputs. Many programs recognize the need to avoid creating dependency. Volunteers are instructed to avoid making promises of material support too early. Relief assistance may be provided on a regular basis, at times of crisis within the family, or at times of crisis within the community. Material support may be provided on a limited basis only to those in greatest need on an irregular or semi-regular basis. Attempts are made to help families to achieve self- sufficiency, or to try to ensure that support is provided from relatives.

Community coping mechanisms include transfers of labor from families in need to those who are better off in return for payments in cash or in kind. Better off members of the community may employ adolescents or children to work in their fields or households. Though such arrangements may be made out of beneficence, it is possible for them to become exploitative.

Within Matabeleland, the concept of the "Chief's Granary" has been revived in recent years. Community members are expected to give a part of their harvest to the chief for distribution to the needy in his area.

Helping children to stay in or return to school: Although this activity might be classified under the previous heading, it is important enough to be considered in its own right. The HIV/AIDS epidemic pushes survivors into poverty, which often leads to children being expelled from school due to nonpayment of school fees. Some programs are specifically targeted at keeping children, especially girls, in school. Primary school fees may be paid on a semi-regular basis (i.e., school fees for first two terms only), and the family may be asked to raise money for school uniforms and equipment in an attempt to reduce dependency.

However, some families are unable to maintain themselves without regular material support. When school fee support is withdrawn for the third term, some children permanently drop out of school; other families are unable to raise support for school uniforms and equipment. Advocacy on behalf of destitute children has resulted in children being allowed to attend school without uniforms, or in fees being waived. This causes an increased burden on other community members.

While payment of school fees is the most common activity, some NGOs have supported community efforts to build, repair, or equip schools in return for a commitment from authorities to allow needy children to attend school free of charge. Sometimes, matching grants are provided that are contingent on raising money or an in-kind contribution from the community.

IGAs, gardens, and revolving credit funds: Most community responses to orphans incorporate some element of income generation on behalf of the beneficiaries. The Zunde Mambo (chief's garden) is an example of an IGA whereby the chief donates a field, and members of the community (usually women) organize to tend the field. The produce is used to support the needy in the community. Some schools have also organized to grow produce be distributed to the needy

Community initiatives illustrate the mechanism of the community safety net, whereby the poor support the destitute. Since most of the volunteers are poor themselves, groups of women often start IGAs to raise money for school fees and essential needs of orphans. Volunteers join together to establish poultry, sewing/knitting, or agriculture projects. Few community groups receive external support. As a result, the amount of support that can be generated to provide to destitute families is often insufficient and intermittent. Analysis of household IGAs operated by caregivers in an orphan support project in Masvingo Province found that 84 percent raised monthly incomes of Z$200 or less, and 14 percent raised incomes of Z$201-$500. Reviews of IGAs are mixed, however. Some critics assert that their value may be measured more readily in social solidarity than in economic gain (see below). For this reason, donors and community groups may want to choose other options for greater economic gain.

"These are get-together projects which keep women busy but out of business. They tend to be highly seasonal, die during the busy agricultural season, and in most cases have done little to improve the standard of living of the rural folk." - Two Agritex Officers, Masvingo District quoted in a UNICEF report on community IGAs, 1997

Involvement of Traditional Leaders

In 1993, the DSW, in collaboration with UNICEF, carried out orphan enumeration in two districts in Masvingo province. Following this, it established a community-based orphan support program. Project organizers worked with community leaders, village community workers and schoolteachers to establish committees to monitor the situation of children in need in their areas.

The involvement of the traditional leaders in the project has been an important strategy. As a result, several other Chiefs in Zimbabwe have revived the traditional practice of Zonde Mambo. According to this tradition, the chief donates a field, which is farmed by members of the community. Any produce is given to needy families such as orphan households in the community.

A number of communities have received grants from UNICEF in order to establish income-generating projects to support orphans in their area.

Practical Help/Livelihood Assistance: Community members may offer help in agricultural activities through the provision of training and supervision, loan of equipment, or help in planting, weeding, harvesting, or food processing. Assistance to families may be provided through assistance in building or repairing homesteads or farm buildings. This area is one in which many communities have succeeded in involving males in the provision of support to destitute families.

Household training: Some community groups have organized specific activities to provide training to groups of children or guardians. Training may be provided in areas such as hygiene, childcare, and agriculture, sewing or household maintenance. Training may be provided at the village level by volunteers or at the community meeting place.

Recreational activities: The recognition by community members that orphans must work hard and forego many of the normal activities of childhood has led some programs to set up sporting and cultural activities such as soccer, netball, traditional dance, and singing.

Creche and child-minding facilities: With the growing numbers of households headed by adolescents and children, some groups have recognized the need for child-minding facilities. In some cases, young children are left at the volunteer's house in the morning and collected by the household head in the afternoon after school or work in the fields.

Community foster homes: Most orphaned children are cared for by members of their extended family. For those unable to be cared for within their extended family, the best alternative is to belong to a substitute family. The psychological and social needs of children are best met through living as part of a family, which is part of their surrounding community and culture. Some programs, such as the Farm Orphans Support Trust

(FOST), have encouraged the establishment of community foster homes or have helped to encourage informal fostering outside the extended family.

Foster Homes On Commercial Farms

Some 2 million people - nearly 20 percent of the population - live on farms. Health, education, and welfare services are poorly developed in rural areas. In addition, many farm workers are migrants from Malawi, Mozambique, and Zambia. The AIDS epidemic causes particular problems to people living on commercial farms whose accommodation is tied to employment and who have few relatives living nearby.

FOST was established in response to the plight of orphans living on commercial farms in Zimbabwe. In addition to orphan registration, household visiting, and awareness raising among farm owners, the project has piloted the establishment of a number of community foster homes. Orphans have been integrated into small family units. Foster parents are supported by farm owners and community members to care for orphans.

Community foster homes may be one answer to the increasing problem of unaccompanied children resulting from the AIDS epidemic.

Linkage Between NGOs and Church Groups

The Families, Orphans, and Children Under Stress (FOCUS) program in Mutare, Zimbabwe, is supported by the Family AIDS Caring Trust (FACT). The program supports community-based orphan initiatives in one urban and five rural sites in Manicaland. Under the program, 138 women volunteers, many of them widows with orphans themselves, are provided with basic training so they can identify and register orphans in the community. In each site, a church leader, together with a committee of other community members, operates the program.

Orphans in need of assistance are identified, regular visits are made, and material support is provided to help children stay in their homes and communities. The most needy are visited the most regularly. During 1998, volunteers reported 59,084 visits to some 6,000 orphans in 2,174 households.

Practical help provided by volunteers included helping children to rebuild their homes, and provision of food, blankets, and primary school fees. Projects have been started to encourage self-reliance.

Identifying ways to support orphans that complement existing coping mechanisms has been an important aspect of the program. Encouraging community leaders to be involved in helping affected families has also been crucial. This, in turn, has encouraged other members of the community to provide support and has been an important strategy for reducing stigma and community rejection.

For example, one family with an older sister looking after several younger siblings had been ignored by the community - “We had no visitors because we are so poor, we have nothing to give them” - until community leaders became involved in helping repair the house. The family now receives support from neighbors.

The total cost of the program in 1998, including transport, depreciation, and salaries, was Z$830,000 (US$21,000). Of total expenditures, 25 percent was allocated for material assistance (mainly maize seed), primary school fees for some 600 children, cooking oil, and soap. Secondhand clothing was distributed to about 1000 families. Thirty-two percent of expenditures was spent on volunteer allowances, uniforms, and community meeting and training expenses, and 2 percent was spent as project materials for IGAs. The remaining 41 percent was spent on FACT salaries, transport, and administration. The cost per visit in 1998 was Z$14 (35 US cents). The cost per family per year was Z$382 (US $9.50).

HIV prevention activities: The recognition that children affected by AIDS are particularly susceptible to HIV infection has led some community groups to establish AIDS awareness

and prevention activities. For example, the involvement of students from local schools who are members of anti-AIDS groups has enabled such activities to be more peer-led and has provided a bridge between out-of-school orphans and their contemporaries who have remained in school.

Volunteer training and motivation: In most programs, the motivation of volunteers to provide care for children affected by AIDS is high and dropout rates are low. This is true even in those programs that provide no material incentives. The recognition by community members of the value of what volunteers are doing, very often linked with their own sense of service to God, are strong motivating factors. Training, the wearing of a uniform, the provision of seed packs, or Christmas bonuses and the opportunity to visit other support programs also serve as strong motivating factors in some programs. (see "Volunteerism" section under "Proposed Approaches and Principles of Action").

There are concerns about maintaining volunteer involvement in programming, especially in the face of rising numbers of children affected by AIDS and increasing numbers of destitute households. Many volunteers are themselves poor and are caring for their own orphans. Volunteers try to earn money to provide for their own family's needs. It is difficult for them to be asked to act as conduits for material support to poor households if their own family is equally poor. It is also difficult to expect that all volunteers should work to raise money or grow food to provide for orphan households if their own family suffers as a result.

Setting up CWFs: A number of community groups have set up ward- and village-level forums in an attempt to involve community leaders in child welfare issues. The establishment of forums enables volunteers to influence decision-making or improve services that affect orphans in their community (see more on CWFs below and in the section "Proposed Approaches and Principles of Action").

NGOs WORKING WITH CHILDREN AFFECTED BY AIDS

A nationwide assessment is needed to identify and appraise the NGOs that work in the HIV/AIDS area, and specifically, those that work with children affected by AIDS. NGOs have particular strengths, which could be put to good use in a coordinated response to AIDS. For example, those with appropriate institutional mandates and management capacity could serve as intermediaries between the GOZ or donors and CBOs. A limited scope tends to prevent a single NGO from undertaking a nationwide intervention. However, NGOs tend to be much larger than CBOs and might best work with these grass-roots organizations.

Home visiting and material support programs

It is likely that more than 50 NGOs directly implement orphan support and visiting programs. Many of these are extensions of existing home care programs operated by mission hospitals, AIDS service organizations, and NGOs. Most programs use home care volunteers who, in addition to home care visits, also visit and provide material support to orphan households. Manama Mission Hospital in Matabeleland, for example, has

registered 1770 orphans and designated 530 as needy due to a lack of basics such as school fees, food, clothing, and soap. Some programs, such as Kubatana, St Augustines Mission, Penhalonga, have established a FOCUS orphan support program with 12 designated volunteers while a similar number of volunteers provide home care support. Activities carried out are similar to those described in the previous section.

NGO-based orphan support programs differ in several important ways from those operated by community groups. NGO-implemented programs are more likely to be better resourced than community programs. Training of coordinators and volunteers is often provided and of a higher quality. Access to income-generating support may be more easily obtained. Reporting and monitoring systems are often better established. However, since many NGO programs identify orphans as a result of home care activities, there is a risk that families who do not receive home care and other vulnerable children may be overlooked. Decisions about the provision of material support may be made by program coordinators rather than community volunteers. Mechanisms should be put in place to ensure appropriate provision of material support, mainly to families that lack other sources of support, so as not to undermine community and extended family coping.

A nationwide assessment should look at NGO programs' ownership (to see if it is local or distant) and the strength of their association with the communities they serve. The most effective NGOs may have strong community orientations, while the least effective may foster dependency, fail to mobilize community members, and lack sustainability. Donor approaches should support local ownership.

Two examples of respected stand-alone child care NGOs that provide regular visiting and material support are the Bethany Project (see box) and the Highfield Community Childcare Project. The latter project has recruited 15 volunteers who are responsible for providing regular visits to children affected by AIDS. Community members were involved in its establishment. The project aims to establish a pilot program that might be extended to other urban areas. Operational and sociological research is being conducted.

NGO Strategies

The nationwide assessment should examine the range and success of NGO strategies for serving children affected by AIDS and determine which NGOs directly implement visiting, IGA, or household training programs. NGOs are also involved in capacity building and other types of activities to support the work being conducted by organizations that directly implement activities.

Brief descriptions of child support activities with examples of implementing organizations follow.

Community Mobilization and Documentation: Some NGOs provide support and guidance to community groups that implement programs for children affected by AIDS. Manuals have been developed (e.g., FACT, Child Protection Society) to support such activities.

Volunteer training: Many NGOs have provided training courses in order to increase the skills of volunteers. In addition, some NGOs have provided funds to enable volunteers to make exchange visits to other orphan support programs. This has proven to be an extremely effective means of increasing both the motivation and skills of volunteers.

Caregiver training: Masiye Training Camp, a Salvation Army training center near Bulawayo, offers training courses in life skills and coping for orphans, as well as teenage parenting courses, to help orphans look after their young siblings (see box). The organization emphasizes psychosocial support and is developing monitoring tools for this important area. Other groups provide training for teenagers in IGAs.

Orphan Visiting Programs - Example

Following discussions with several NGOs, a British volunteer started the Bethany Project in Zvishavane District in 1995. The project currently has three staff members and a budget for 2000 of around US$20,000. The project started in two wards with 35 volunteers who were responsible for identifying children affected by AIDS and providing regular visits and small amounts of material support. Each ward has 6-8 villages, and each village has a subcommittee that meets once per month

The program involves community members from the outset. Church leaders, chiefs, and ward committees provide home-based assistance to orphans through maintaining their house or paying building funds or tuition levies. Volunteers are recruited from local churches and receive three days of initial training, together with other community members. Volunteers receive a bag of sugar and a bar of soap at Christmas as a material incentive. To date, no volunteer has dropped out of the program.

In 1997, the program expanded to an additional 16 wards to cover the whole district. The project now involves 656 volunteers. Children are categorized on three registers: the neediest orphans (4,952), other children in difficult circumstances (3,052), and other orphans (4,046). Only the first two categories (8,004 children) receive regular visits and material support. School fees, most of which are for primary schools, are provided for some 900 children. Five AIDS action HIV prevention groups and seven IGAs have been launched. Problems identified include lack of incentives for volunteers, lack of secondary school fees, large numbers of family deaths, and sexual abuse of children.

Providing material support: Some NGOs provide material support or small grants to community groups. This support is used to either help individual families or to help set up IGAs.

Networking: Although there is a National AIDS Commission, there is no separate national body responsible for coordinating activities specifically designed to support children affected by AIDS. (The nationwide assessment may look at appropriate mechanisms for coordinating these activities.)

Private efforts are underway to coordinate support for children. In Bulawayo, Hope for a Child in Christ (HOCIC) brings together 30 church groups, which are responsible for implementing some 18 orphan support programs. The organization hopes to employ its first staff member in 2000. The Child Protection Society, FOST, FACT, UNICEF and the DSW have all been responsible for bringing together NGOs and community groups responding to children affected by AIDS.

Scaling out and replication: Some NGOs provide training for other NGOs and CBOs specifically to encourage the development of community-based programs. Many of these are organizations that conduct training and host visits by other organizations as part of the SAT-initiated School Without Walls program (see box). (Also see section on "Principles of Action" for more on scaling out and replication.)

IGAs: Some programs seek to strengthen community-based social safety net mechanisms through training in income generation, revolving credit schemes and village banks, and through the extension of credit. (Also see more on this topic in the section "Proposed Approaches and Principles of Action.")

Families may also be helped to improve their ability to generate an income through:

- grants to purchase equipment such as sewing machines, grinding mills, and irrigation equipment;
- credit schemes whereby families who are able to provide security or have a record of repayment of previous loans are granted credit to extend their IGAs; and
- training in business skills, marketing abilities, and production technology.

Such activities are usually provided as a result of partnership with external organizations. Microfinance organizations (e.g., Opportunity International) may establish linkages with organizations working with children affected by AIDS to strengthen these income-generating activities.

Research: In general, the impact of HIV/AIDS is still a relatively new problem and research is needed, including research related to optimal ways of addressing the needs of children affected by HIV/AIDS. A nationwide assessment should seek to list critical research questions and identify organizations that are well-suited to undertake research and share results.

In general, NGOs do not focus on research. In some cases, NGOs may have this capacity and mission. FACT, Child Protection Society, and Masiye Camp, for example, were established with a capacity to conduct research through their programs.

Policy Development and Advocacy: A nationwide assessment should seek to describe the overall policy environment and identify needs and opportunities. It should also determine which groups have conducted advocacy, how effective they are, and what advocacy challenges might deserve the highest priority.

Orphaned children frequently experience exploitation. Orphans lack the protection normally provided by their parents. In such cases, the state is responsible for the protection of children from neglect, abuse, or harmful child labor. In practice, many governments lack the capacity to fulfill these obligations. Some NGOs have played an important role in encouraging the development of policy, strengthening the development of CWFs, and raising awareness of the issues surrounding children affected by AIDS. Some programs

have sought to build the capacity of social welfare departments, which have a statutory responsibility for child welfare.

Statutory agencies, such as social welfare departments, lack resources to target those in greatest need. In a study of 211 needy orphan families in a remote area of Zimbabwe, 83 percent failed to go to the welfare office because they did not know of its existence or lacked the resources to travel the long distance to the district center.

Other NGOs have worked to increase the ability of community groups to provide protection for vulnerable children. Community groups have become involved in surveillance of children in especially difficult circumstances through raising awareness. Some groups have become advocates concerning the plight of vulnerable children, highlighting issues such as land and property inheritance, sexual abuse, and exploitation.

Existing Psychosocial Support Programs for Children Affected by AIDS

There are few programs that address the psychosocial needs of children affected by AIDS. The programs described below are complementary to other programs, which focus more on material/skills support, and are facilitating the integration of the psychosocial component with a holistic programming approach.

Memory Book Project

Developed in the United Kingdom but adapted and widely used in Uganda, the Memory Book is a simple tool to assist ill parents in recounting the family history and memories of their children's early childhood. It helps children affected by AIDS to strengthen their identity and to prepare a will in a timely and sensitive fashion. Action Aid Zimbabwe is planning to invite a Ugandan facilitator for 2-3 months to train and work with PLWHA support groups in utilizing the Memory Book.

Humuliza Project

Terre des Hommes Switzerland has developed, together with Connect Zimbabwe a manual for psychosocial support programs for teachers, volunteers, and health workers in the Kagera District in Tanzania. Different manuals were developed to support professionals and volunteers in integrating psychosocial support for children in all activities. Further material has been developed for group work with children affected by AIDS to address issues of grief, trauma, and confidence building. Some groups in Zimbabwe are using the manual.

Salvation Army Masiye Camp

This program targets community-based orphans and provides a short life skills camp with recreational activities to support psychosocial coping of orphans. The 10-day short camps integrate bereavement support, hygiene, first aid, nutrition, and confidence building recreational activities (e.g., climbing, canoeing).

For teenagers heading households, the camps include parenting skills and household management. The camps train children to assess their own situation, analyze their problems, and take appropriate actions to solve problems with the assistance from the community. Presently the program is expanding to transfer the concept of psychosocial recreational work into communities on an ongoing basis. Youth group leaders are trained and supported to start recreational socialization programs in their communities.

The involvement of youth to support children who have experienced the consequences of HIV/AIDS is helpful and may lead to desired behavior change and improved prevention.

Connect and Contact

Connect (Harare) has been extensively involved in counseling and training. It offers training in child counseling and support initiatives for psychosocial support of children affected by AIDS, such as the Humuliza Project in Tanzania. Contact in Bulawayo, a sister organization, supports community-based orphan care programs with counseling training and offers a course in child and play therapy counseling.

Island Hospice

Island Hospice (Harare), with the support of UNICEF, has developed a program to assist children in the grief process. The Bulawayo branch last year started to train HOCIC coordinators of community-based orphan programs in bereavement support. Involving youth in this process has been beneficial.

NGOs LINKING WITH COMMUNITY INITIATIVES

One proposed model of organization for assisting children affected by AIDS is to partner NGOs with CBOs. Experienced NGOs, with professional staff and management capacity would presumably work directly with the GOZ and/or donors to assist smaller, grassroots CBOs to conduct direct service activities. (While this appears feasible, it would be advisable for a nationwide assessment to examine a wide variety of approaches)

Community-based initiatives are often better able to provide effective support to children living under especially difficult circumstances when they receive assistance from outside organizations. Outside agencies can effectively provide support to CBOs to implement programs to support children affected by HIV/AIDS.

Care should be taken so that externally supported programs do not undermine or displace community coping mechanisms through the establishment of activities or the provision of material support with limited community participation. National and international NGOs seeking to support orphan families should be mindful of this issue. Employees working with organizations based outside the community are frequently unable to target the neediest households. Such groups are likely to seek to be accepted by community groups. NGOs should encourage community-owned responses to avoid dependency.

NGOs have a key role to play in responding to community needs by providing technical and other types of support to community groups implementing orphan support initiatives. Partnership is a key component in strengthening community support initiatives without contributing to increased dependency among community groups. Outside agencies can provide access to material resources for distribution by community groups to needy households. They can provide training and capacity building in areas such as community mobilization, volunteer mobilization, recordkeeping, organizational development, psychological assessment, and support.

Such partnerships demand trust and mutual respect for the particular skills that each organization brings to an activity. In particular, NGO partners should consult closely with community groups and should be careful to ensure that community organizations receive credit for the activities carried out.

CHILD WELFARE FORUMS

Child Welfare Forums (CWFs) were originally established by the GOZ, with the support of UNICEF, to address children's needs at the district level. They comprise governmental and nongovernmental entities but do not have legal status. CWFs function well in some districts but are not functional in others. One of the key constraints to establishing CWFs is the limited number of social welfare officers at the district level.

CWFs should adopt an intersectoral participatory approach for the care and monitoring of orphans and vulnerable children at all levels. They should eventually have structures at the national, provincial, district, chief, and village levels.

The CWF is a loose network of organizations whose interest is the welfare of children. Member organizations are to be collectively and individually, directly or indirectly engaged in child advocacy and child welfare issues. CWFs are to be initiated by officers of the DSW who will eventually hand over leadership to representatives of NGOs and members of the communities. CWFs are currently active in some regions. In others, especially at the more local levels, they have not yet been established.

Ongoing responsibilities of the CWFs might include:

- Coordinating all activities aimed at improving the welfare of children;
- Carrying out research on the circumstances of children affected by AIDS;
- Mapping strategies to fulfill children's rights;
- Monitoring the situation of children at all levels;
- Advocating for the rights of children by persuading policymakers and leaders to honor their obligations to children;
- Raising awareness and educating communities on children's rights;
- Mobilizing community initiatives in support of child welfare;
- Raising funds to support children affected by AIDS;
- Networking to rationalize service provision and to avoid duplication; and
- Advising government and others on child welfare issues.

MODELS OF COMMUNITY-BASED CARE

In order to support community initiatives, four models of community-based orphan care have been developed and all but the mining model have been implemented on a pilot basis. The DSW and UNICEF provided support for these programs.

Rural Model

In an effort to address the growing number of orphans in the Masvingo Province, the CWF piloted a rural model of community-based orphan care in Masvingo and Mwenezi Districts.

Activities include:

- Enumeration exercises and establishment of key issues in the community context;
- Social mobilization with awareness campaigns and sharing of experiences;

- Establishment of chief and village CWFs to monitor orphans at community level;
- Launching community IGAs in support of orphans; and
- Program evaluation.

Urban Model
The rural model is based on using traditional leadership structures for community support and monitoring of orphans in the community context. These structures do not exist in the urban context. The Bulawayo Provincial CWF was tasked to pilot the urban model of care. The following key steps were followed:

- Enumeration of orphans and children in difficult circumstances;
- Implementation of a participatory situation analysis of urban children (more than 390 caregivers and children were interviewed);
- Establishment of CWFs at the urban district level. (Community CWFs were integrated into the existing structures of the task force of home-based care, which was initiated by the city health department some time ago. The integration of residence associations, counselors, teachers, and pastors in the CWF was crucial);
- Integration of orphan support into existing home-based care programs; and
- Evaluation and monitoring.

Many urban communities in Bulawayo have responded by starting up community-based initiatives through program exchange visits in different neighborhoods.

Commercial Farm Model
As the situation on commercial farms is distinctly different from rural communities, there was a need to develop an alternative model of care. The FOST program spearheaded this model. It involves:

- Ongoing enumeration;
- Mobilization of farmers and farm workers to establish, own, and monitor the farm-based support program;
- Creation of innovative and appropriate informal fostering arrangements within farm villages.

The national response by FOST might well demonstrate globally one of the largest and most comprehensive private sector program in support of children affected by AIDS.

Mine Model
Similar to the commercial farms, in mine compounds, accommodation is tied to employment and few relatives live nearby. However the social context is more of urban nature than on commercial farms. As a result it was deemed necessary to develop a model of community care for mines. This model is presently being developed.

VI. GOVERNMENT, ADVOCACY, AND DONOR RESPONSE

The scope of this Background Paper is limited to children affected by AIDS. While a summary of GOZ AIDS-related structures and services would be useful, it is beyond the scope of this document. It is recommended that the planned nationwide assessment provide an overview of the AIDS-related structures and services of the GOZ and donor community. An overview of GOZ and donor views on advocacy issues and approaches would be also helpful.

GOZ CHILD-RELATED POLICIES

During the World Summit for Children in 1990, Zimbabwe was among the first nations to ratify the Convention on the Rights of the Child. In 1995, Zimbabwe also ratified the African Charter on the Rights and Welfare of Children. These instruments provide a valuable framework under which to address children's rights issues at all levels. Institutional bodies, such as the National Plan of Action for Children (NPACC) Secretariat, have been appointed for monitoring and reporting on implementation progress. The nationwide assessment could assess the extent to which the NPACC is known and supported.

The CWFs, which bring together government, donors, and civil society, have the potential to complement the effort by developing systematic monitoring mechanisms for policy implementation and reporting. The nationwide assessment might examine the current status and the potential role of the CWFs.

The legislative framework related to children is found in the following acts: Child Protection and Adoption Act [Chap 5:06] (presently being amended to incorporate the CWF); the Education Act [Chap 25:04]; and the Guardianship of Minors Act [Chap 5:08]. One key question is whether donor organizations and others have taken action or supported initiatives growing out of this legislation.

Several key national policies and plans are under development or were recently implemented that affect children's rights and welfare: a new constitution; the newly launched HIV/AIDS policy; and draft policies on youth and orphans, economic decentralization, and land reform. Strategies are presently being formulated for poverty alleviation and enhanced social protection.

These plans and polices can have a positive or negative effect on children, depending on the extent to which children's rights are acknowledged, prioritized, and acted upon. The nationwide assessment might establish a baseline analysis against which the long-term effects of these plans and policies can be measured, as initiatives and programs begin to be implemented.

GOZ HIV/AIDS POLICIES

In 1995 the GOZ initiated the development of a national HIV/AIDS policy. USAID provided funding for a broad-based consultative process to develop consensus on priorities and ensure that the various stakeholders had full ownership of the outcome. After four years of planning, on December 1, 1999, the president of Zimbabwe officially launched the national HIV/AIDS policy.

Also in 1999, the GOZ increased its commitment to addressing HIV/AIDS through other actions. First, the government announced its intention to collect an "AIDS levy" (a 3 percent surcharge on taxation). Second, the parliament approved an act to establish a National AIDS Council (NAC) to facilitate a more multisectoral government approach. The NAC, led by a presidential appointee, will assume responsibility for HIV/AIDS resource mobilization, policy development, and overall coordination of HIV/AIDS programs.

In conclusion, although it is beyond the scope of this document to do so, a nationwide assessment might include in its scope the following useful planning information:

- establishment of a baseline situation analysis for the NPACC and other policy initiatives;
- identification of useful measures or indicators of progress under these initiatives; and
- collection and analysis of early feedback on operational initiatives.

For information purposes, the following are guiding principles and strategies related to children affected by HIV/AIDS that are included in the approved HIV/AIDS policy:

- Develop community home care and support it as an essential component of the continuum of care for PLWHAs and their families;
- Promote orphan care within the community;
- Cater to the needs of children in households affected by HIV/AIDS, paying special attention to the children's socialization and education;
- Protect the rights of children and young people with, or affected by HIV/AIDS;
- Avoid any form of discrimination against children affected by HIV/AIDS;
- Support and counsel children to help them to cope with HIV infection and/or living in a family with someone infected with HIV/AIDS;
- Encourage and support orphaned children to remain in their community, especially within the extended family;
- Educate the community and civil society on the importance of fostering and adopting orphans;
- Encourage shared responsibility for the care of orphans within society. This includes financial, material, and psychosocial support from the extended family, community, government, NGOs, and churches. Placement of orphans into institutions is discouraged as a policy;

- Develop sports and other recreational programs to help occupy youth in a creative way and assist in the socialization of orphans in the community;
- Protect children and young people from any form of abuse that is likely to expose them to HIV infection;
- Intensify efforts to increase community awareness of child abuse, particularly by engaging teachers, parents, police, churches, and other community and traditional leaders;
- Encourage children and youth in any setting to report sexual, psychological, and physical abuse. Counseling should be made available and accessible;
- Promote education and stronger enforcement of laws that prohibit the use of young girls for reparation or barter; and
- Encourage changes in cultural practices that are likely to fuel the HIV epidemic.

As above, a nationwide assessment ideally would provide information on the degree of support and acceptance of these policies in government, donor, and community groups. It might also provide feedback on areas of disagreement and on suggestions for change.

ADVOCACY

Policy frameworks define enabling environments, create incentives or disincentives for change, and channel resource flows. Advocacy efforts can change policies and redirect public and private investment towards constructive solutions to problems. Advocacy is a significant channel of communication between civil society and government regarding policy and social investment. A nationwide assessment might provide an overview of the range of advocacy issues and approaches, and their various degrees of success, strengths, and weaknesses.

Note that children do not yet have a political voice in Zimbabwe, although approximately 50 percent of the population is under 15 years old. Nor do orphans have a voice. Child advocacy is therefore a potentially important function, and advocacy for children affected by AIDS will become increasingly critical as the number of these children rises. Because gender is such a significant issue influencing the impact of HIV/AIDS on women and their families, advocacy for women is also critical to the welfare of children affected by HIV/AIDS.

Advocacy for Children

Just as advocacy for children is a subset of overall political advocacy, advocacy for children affected by AIDS is a subset of AIDS advocacy. A nationwide assessment might look at the extent or lack of advocacy opportunities or obstacles in both a general sense and in terms of specific advocacy topics. In doing so it could draw on broader advocacy surveys and studies. Approaches might include identification of outstanding individual and organizational advocates for children, which could lead to eventual support from donors.

UNICEF has been a leading child advocate in Zimbabwe, and its role is significant. However, multiple voices converging on the same issues can advocate much more

effectively than one lone voice. UNICEF's voice is distinctive and international. A nationwide assessment might gauge governmental, nongovernmental, and public support for child's rights as they relate to children affected by AIDS. The child rights framework is now the touchstone of UNICEF's advocacy for children. UNICEF's work will become more effective as support increases for children affected by HIV/AIDS.

Additional issues to examine in a nationwide assessment are public and private perceptions of various advocacy groups (local, regional, national, and international) in Zimbabwe. One line of reasoning is that local voices are the most effective advocates, and are by far more sustainable and committed. This reasoning suggests they are also more responsive. Is this the general view? Or are regional, national, and international advocacy groups valued as well? It is important to determine which type of advocacy is most effective in promoting change.

Advocacy groups are often catalysts for participatory action research, which is needed on many issues facing children affected by AIDS. Advocacy groups typically collect and analyze information from stakeholders, and disseminate it to policymakers and other audiences. They frequently conduct public education campaigns and offer training and education.

DONOR RESPONSES

An overview of donor responses to HIV/AIDS is important but beyond the scope of this document. A nationwide assessment could include a more complete examination of donor responses to HIV/AIDS in general. The nationwide summary might update existing lists or guides to donor-funded, AIDS-related interventions in the health sector and elsewhere. An up-to-date, complete list could prove useful to coordination efforts.Available information indicates that there are few donors with programs able to enhance capacity of community responses to children and families affected by HIV/AIDS.

Donor involvement is expected to increase since government acknowledges that it cannot cope alone with the large numbers of children affected by the AIDS epidemic. Donor community comments indicate a desire for a greater number and variety of reliable implementation mechanisms. A nationwide assessment of donor views might include their perceptions of the most reliable mechanisms for implementation of assistance to children affected by AIDS.

Donor coordination is imperative to begin to address the vast needs of children affected by HIV/AIDS with the limited resources that are available.

Building on the limited analysis presented here, a more complete national analysis is needed and could potentially strengthen and facilitate ongoing coordination among donors, the public sector, NGOs, religious groups, and community groups. It could optimize the complementarity of programs among donors and with the GOZ. Many donors have expressed interest in participating in such an effort. A complete analysis would provide

information on donor support, such as the amount and purpose of funding, and the nature of the target area or population.

USAID/Zimbabwe has the opportunity to take a leading role in supporting community responses to children and families affected by HIV/AIDS. This includes the development of innovative implementation mechanisms that involve government and use existing structures at all levels. With regard to CWFs, three donors are presently active in their support: UNICEF, Save the Children Fund (United Kingdom), and Redd Barna.

The following is a description of some of the donor responses presently taking place in Zimbabwe with regard to children affected by HIV/AIDS. Not listed are additional donors that include programs in their portfolios that indirectly benefit children affected by HIV/AIDS. The nationwide assessment should attempt to identify these indirect donor benefits for children, even if only broadly.

Donors Presently Active in Assistance to Children Affected by HIV/AIDS

UNICEF:
UNICEF has supported a national enumeration exercise and the development of rural, urban, farm, and mining models of care for children affected by HIV/AIDS. UNICEF also supports a number of CBO and NGO activities that focus on children affected by HIV/AIDS (e.g., Masiye Camp, Tsungigirai). UNICEF is presently working on a new national plan for 2000 – 2005. This plan includes a programmatic focus on "community responses to orphans and other children at risk," to increase the number of children affected by HIV/AIDS who will benefit from quality community-based support services.

Redd Barna (Norway):
In an effort to enhance the capacity of CWFs at the national and provincial levels, Redd Barna is supporting the DSW with ten social workers focusing on CWF coordination. Nine are working at the provincial level and one is employed at the national level. In addition, Redd Barna established an inventory of children's organizations and organizations that work with children.

DANIDA (Denmark):
DANIDA is supporting four programs that have launched a community-based orphan support component out of their embassy funds (i.e., Rujeko, Mashambanzou, Lubancho House, FOST).

CIDA (Canada):
CIDA supports the SAT program (Canadian Public Health Association) to act as a grant manager. SAT, in turn, supports eleven home-based care programs that include an orphan support component (e.g, Tshelanyemba, FACT).

Oak Zimbabwe Foundation (Zimbabwe):
Oak Zimbabwe Foundation, a private foundation, supports 16 programs working with children affected by HIV/AIDS. The foundation initiated an informal donor gathering to facilitate coordination related to programming for children affected by HIV/AIDS issues.

NORAD (Norway):
NORAD supports a number of home-based care programs that have incorporated an orphan support component (e.g., Howard Hospital).

SIDA (Sweden):
SIDA is active in the education sector and is exploring ways of supporting schools in return for scholarships for children affected by HIV/AIDS. SIDA is in the process of establishing an Africa regional center of excellency related to HIV/AIDS activities.

Save the Children Fund (United Kingdom):
Save the Children activities focus primarily in the Binga and Kariba Districts, on commercial farms, and in some mining towns. The programs focus on all children at risk in those areas.

VII. PROPOSED APPROACHES AND PRINCIPLES OF ACTION

This section includes a number of proposed programmatic approaches and principles of action. These approaches are offered as a starting point for dialogue. The expectation is that donors and other actors will adapt these or similar approaches for their work. There is an advantage to adopting common approaches, where appropriate, but there is also room for diversity.

The term children affected by HIV/AIDS might include:

- Those who have lost one or both parents or caregivers;
- Those who are living in a household with a parent or other family member who is ill;
- Those who are living in families whose resources – financial and emotional – are over-stretched as a result of increased numbers of children for whom they are responsible; or
- Those who live in communities severely affected – economically and socially – by HIV/AIDS.

In general, community responses to the needs of children affected by HIV/AIDS should:

- Not single out AIDS orphans. Targeting specific categories of children potentially leads to increased stigma and discrimination and can, ultimately, cause harm.

- Direct assistance to the most vulnerable children and households, regardless of the specific causes of their vulnerability.

- Facilitate development of a system to prioritize assistance through a representative and participatory process involving communities and affected children.

Specific suggestions for programmatic approaches include:

STRENGTHEN CARE AND COPING CAPACITIES OF FAMILIES AND COMMUNITIES

In nearly all areas heavily affected by HIV/AIDS, the first line of response to the needs of children are extended families. Families show remarkable creativity and dedication in coping with the impact of the disease. However, the scale of the pandemic is causing enormous strain on the traditional coping mechanisms of the extended family, eroding its capacity to care for those suffering from or left behind by HIV/AIDS. In many areas, communities have informally and formally organized around providing support to families in their effort to cope with their losses. Enhancing the capacity of responses by families and communities to address the needs of children/youth affected by HIV/AIDS may be the most effective, efficient, and sustainable approach to fill the widening gaps in traditional safety nets. Programs should affirm and reinforce family and community responses to the crisis.

MINIMIZE UNINTENDED CONSEQUENCES – DO NOT UNDERMINE COMMUNITY EFFORTS

Supporting community initiatives in a sustainable manner is of primary importance. However, in doing so, there is concern that new, donor driven efforts will compete with and disable local efforts. There is also concern that large amounts of funds may change the nature of the humanitarian incentives that currently drive local efforts. While there is need at the community level for emergency funds to provide temporary support for basic supplies such as food, shelter, and school fees, this support must be paired with efforts that will address long-term needs that will continue after temporary funding is no longer available. Implementation should involve coordination with local efforts as a crucial first step. NGOs and CBOs should receive support to achieve a level of capacity that will maximize long-term effective and equitable distribution of material resources when these are available. This often includes development of systems by the community to identify those most in need through representative and participatory methods. Program design and implementation should be consistently monitored to assess their contribution to community responses that can be sustained as the epidemic continues to affect children and their families.

INVOLVE YOUTH AS PART OF THE SOLUTION

Involve adolescents as part of the solution; they are in a unique position to provide support to each other, to younger children, and to those who are ill as a result of HIV/AIDS.

Programs should address the needs of children of all ages, including adolescents. Interventions should include emotional, economic, educational, and social support. Youth should be involved and consulted to the greatest extent possible in design and implementation. Be mindful of factors that contribute to increased risk of infection of youth.

Youth may:

- Experience stigmatization, discrimination, and marginalization;
- Be responsible for the support of younger siblings when a parent dies and face pressure to exchange sex for money or gifts;
- Face increased vulnerability to sexual abuse or other violence, especially if HIV/AIDS has pushed them onto the street; or
- Become more emotionally vulnerable and risk sexual relationships to fill emotional needs.

Research is needed to examine the relationship between involvement in care and support efforts and HIV/AIDS prevention among youth, through anti-AIDS clubs, youth development groups, and other activities.

VALUE VOLUNTEER SUPPORT AND BUILD CAPACITY FOR VOLUNTEERISM

Volunteers are at the core of community responses to vulnerable children. It is volunteers, most of whom are female, who manage the day-to-day supervision of support activities; identify, assess, and try to meet the needs of vulnerable children; counsel families in distress; take food and other material support from their own households to those for whom they are caring; and care for their own children and families, often working to bring income into their own households.

In order to support and strengthen community responses, consider how best to support the volunteers who are the essence of these responses. To support volunteers, NGOs and CBOs can:

- Provide uniforms to garner increased status and respect in the community;
- Facilitate regular meetings so that volunteers can share experiences and information and provide peer support;
- Support exchange visits so that volunteers can share experiences and information with other CBOs and NGOs;
- Make microfinance or IGAs available to volunteers for their own economic growth and/or to support care of vulnerable children;
- Provide high-quality training to increase the capacity of volunteers (i.e., counseling, care of PLWHAs) and instill a sense of personal worth and competence; and
- Provide modest financial bonuses, especially during Christmas time or other special occasions, if funds are available.

FOSTER LINKAGE BETWEEN HOME-BASED CARE AND SUPPORT TO CHILDREN/YOUTH

HIV/AIDS has an impact on all members of a household–infected adults, non-infected adults, and children. Programs that target children affected by HIV/AIDS are often undertaken in isolation from programs that provide care to people living with AIDS. However, there are many care initiatives that have been able to maximize the complementary efforts of the two types of activities. Integrated programming more effectively responds to the reality that the vulnerability of children in AIDS-affected households begins long before the death of a child's parent(s). Children whose parents are ill as a result of AIDS experience the psychosocial distress of seeing a parent approach death, as well as the economic deterioration of the household that often accompanies chronic illness of the person who is the primary source of income.

Integrating attention for children into the provision of care for those who are infected by HIV/AIDS facilitates earlier identification of these children and earlier action to assist them. In fact, it is often home-based care providers who are the most vocal and effective advocates regarding the need for enhanced community involvement with children affected by AIDS. Therefore, where possible, it is advisable to link programs of care and support for people living with HIV/AIDS and those that focus on the needs of children and youth who are affected by the disease. Models for linking the two related types of activities include:

- Programs that integrate activities focusing on care and support for people living with HIV/AIDS and those that focus on the needs of children and youth who are affected by the disease into a single intervention; and
- Programs that remain separate but link related interventions to maximize coordination and complementary efforts.

LINK PREVENTION WITH SUPPORT TO CHILDREN AFFECTED BY HIV/AIDS

It is imperative that care and support activities for children and families affected by HIV/AIDS incorporate prevention and mitigation efforts. Recognition of the extremely high prevalence of HIV/AIDS in Zimbabwe continues to rise, as does the recognition of the need to support children affected by the disease. Both prevention of further spread of the disease and mitigation of its effects must be supported with the limited resources available for HIV/AIDS–related efforts.

Although evaluation of the relationship between prevention and mitigation efforts is still needed, participation in activities providing care to children and/or adults may reinforce prevention through the following means:

- Making HIV/AIDS a more concrete reality in the minds of program volunteers and other caregivers where denial about HIV/AIDS exists;

- Stimulating a more realistic assessment of personal risk among community members and a better understanding of potential consequences for themselves and their families;

- Increasing opportunities to provide prevention information;

- Generating hope and the sense that it is possible to control the spread of HIV/AIDS through solidarity, empowerment, and community action; and

- Providing an acceptable starting point for dialogue in communities that are resistant to discussing sex-related issues.

Models are needed for the most effective ways to integrate activities to maximize impact on both prevention and mitigation. Lessons learned from these efforts should be widely disseminated.

EMPHASIZE COMMUNITY CARE

There are a wide variety of reasons to support community-based options over institutional care in Zimbabwe. Traditionally, orphans in Africa have been cared for by kinship-based family systems. The national HIV/AIDS policy in Zimbabwe emphasizes community care of children affected by HIV/AIDS, with priority given to care within the extended family.

Though there are increasing stresses to the capacity of extended families and communities, in most cases institutions are not a feasible option for a number of reasons:

- Orphanages generally do not adequately meet children's developmental needs, especially those of younger children. Children also do not develop the support networks they will need as adults;
- As has been seen in many countries where institutional care is available and families are under economic stress, children are often sent to institutions as an economic coping mechanism;
- Institutional care is not economically feasible for large numbers of children. The cost of supporting a child to live in an institution is substantially higher than the cost of care by a family. Cost comparisons conducted in Uganda showed the ratio of costs in an orphanage to be 14 times higher than those in community care. Other studies have found a ratio of 1:20, or even up to 1:100; and
- There is a significant lack of institutional capacity. By 1994, 38 registered institutes in Zimbabwe were operating at 126 percent of capacity while caring for 2,794 children. If only 10 percent of the anticipated number of orphans require institutional care, the target population would equal 60,000 children.

Institutions may be need in cases of emergency, especially as an interim solution, while a fostering situation is arranged. An alternative model for institutions has involved transformation of children's homes into community-based resource centers to help families maintain children in the community. Such centers could offer day care for foster parents or

parents in need of relief; support groups; counseling; training in parenting skills; and skills training programs for older children.

SCALING UP AND SCALING OUT: INTEGRATE WITH RELATED ACTIVITIES IN OTHER DEVELOPMENT SECTORS

In many regions of Zimbabwe, there are opportunities to integrate with activities initiated in other sectors that mobilize communities around issues such as health, development, and water sanitation. Integrating a focus on vulnerable children into community efforts could contribute to increasing the scale of the response to children affected by HIV/AIDS. Empowered communities can identify priority problems for the community and develop, contribute to, and pursue sustainable solutions to those problems.

Two examples of programs that could possibly contribute to large-scale community responses to children affected by AIDS are: 1) the Community Action Project (CAP), coordinated by the DSW and the Social Development Fund (SDF), and 2) the UNICEF water project approach.

The CAP program has two major objectives: 1) To strengthen the local capacity of communities to identify and prioritize needs; plan and implement solutions; manage and maintain investments; and apply the experience and lessons learned to future needs; and 2) To promote participatory and collaborative planning and implementation of projects through community partnerships with Rural District Councils (RDCs), government agencies, NGOs, and the private sector.

Water projects supported by UNICEF focus on the community-based management of water resources. The projects work with the RDCs and could serve as a guide in terms of identifying and implementing projects through local structures and thus, perhaps, contributing to increased sustainability of activities focusing on children affected by HIV/AIDS.

In these types of activities, communities may already have been mobilized around a specific development activity. A process and structure may have been developed and might be operational and potentially sustainable. In communities affected by HIV/AIDS in Zimbabwe, where there are large numbers of people who are ill and children and families who are directly and indirectly affected by the disease, it may be feasible to work within structures that are already functional. Active community groups, if they are given support in terms of training and eventually in terms of resources, may be optimally positioned to recognize the affect of HIV/AIDS in their community, identify those who are most vulnerable, develop action plans to address their needs, and implement those plans. In this manner, integrating a focus on children affected by HIV/AIDS could potentially increase effectiveness, efficiency, sustainability, and the expanded reach of these activities.

Scaling Out - An Example of Replication

A church group near Mutare established the first FOCUS program in 1993. An evaluation in 1994 found the program had succeeded in identifying a large proportion of orphans in the target area, had identified the most needy orphan households, and had mobilized the community to provide regular visits and support to these households at low cost.

At a workshop in 1994, a Methodist pastor from a different region heard about the program and asked FACT, the facilitating NGO, to help establish the program in his area. In 1995, the FOCUS program was replicated in his area and at a Baptist mission in another district. From 1997 to 1999, the program was replicated at four additional sites. By 1999, FACT supervised 9 FOCUS sites with 178 volunteers providing regular visits to 2,764 orphan households.

The supervisor of the first FOCUS replication site visited his home area in another province in 1995. There he spoke to another Methodist pastor about FOCUS. The pastor requested that FACT assist him in establishing a FOCUS site. The program now involves 98 volunteers, covers nearly half of Murewa district with two centers, and provides visits to some 1500 orphans. In 1998, the pastor spoke about his program at a national Methodist conference. As a result, one of the conference participants went back to his home area and set up a FOCUS program, which now employs 35 volunteers and provides support to 320 orphans. Three additional FOCUS programs have been established by other Methodist pastors in the same province as a result of contact with these two programs.

The project also acted as an impetus for other groups to establish similar programs. FACT operates a Regional Training Program and, as a result of exposure to FOCUS program sites, new orphan programs have been established in Malawi, Kenya, Zambia, and Zimbabwe.

SUPPORT MONITORING AND EVALUATION (M&E) FOR QUALITY PROGRAMMING

A plan for M & E of programs that address the needs of children affected by AIDS should be developed and utilized to enhance the effectiveness of the organization and its activities. Data should be shared and jointly analyzed by program administrators and participants (including volunteers and the community) to improve planning and implementation, as well as to meet reporting requirements.

Monitoring: Community enumeration is often the first step in developing systems for monitoring activities. It identifies the number of children in need. Community members identify and at the same time often register and prioritize vulnerable children within the community. [The term "monitoring" is used here to denote a system that tracks the occurrence of activities that are identified as being important to achievement of program objectives.] As a result, children most in need of support are selected and assigned to volunteers, whose activities are then systematically recorded.

Evaluation: The term "evaluation" is used to indicate the process by which data is collected and used to determine whether, in fact, the objectives of a program are being met.

Monitoring the activities of the project will assure that activities are being conducted as planned. Evaluation will determine how well these activities are being conducted. Evaluation will enable organizations to determine which objectives are being met and which are not.

Technical support for M&E: A framework and methodology is currently being developed in Washington, DC, with support from USAID/Global Bureau, to provide support to implementing organizations and communities to develop M & E plans based on program objectives.

DEVELOP BETTER PRACTICES AND LESSONS LEARNED

Value of Developing and Testing Innovative and Creative Approaches: The GOZ, communities, donors, religious groups, and NGOs are attempting to meet the needs of vulnerable children through a variety of approaches. These include community mobilization, microenterprise development, community-based support, material assistance, counseling, and residential care. Commitment is needed to identify the types of approaches that are most effective, efficient, and sustainable, as well as appropriate conditions under which they should be applied. Lessons learned should be shared with local and global partners.

The following are examples of questions that could be addressed through research implemented in conjunction with activities that address the needs of children affected by HIV/AIDS and their families:

- What is the effectiveness and cost of different models of community-based activities that focus on vulnerable children?
- Is there a positive, synergistic effect of combining prevention efforts with activities that address the needs of children affected by HIV/AIDS at the community level?
- What is the effectiveness and cost of a model that focuses on youth and combines prevention and livelihood skills?
- Is the integration of activities addressing children affected by AIDS into current community mobilization efforts an effective, efficient model to scale up?
- What are the effects of providing material support to communities responding to the needs of children affected by AIDS? What modifications maximize the positive impact of providing support, and minimize potential negative effects (i.e., dependency, weakening of community)?
- How effective are various approaches in supporting volunteers to maintain quality and dedication of services?

LINK ECONOMIC OPPORTUNITY SPECIAL OBJECTIVES (SpOs) TO HIV/AIDS MITIGATION

A family's ability to cope with the impact of HIV/AIDS, which might include the loss of productive labor, increased medical expenses, and absorbing orphaned children into the household, depends a great deal on the state of the household's economic resources before,

during, and after the disease affects it. Some potential ways for microfinance projects, IGAs, and/or skills development to mitigate the effects of HIV/AIDS include:

- Providing opportunities to increase savings and resources before crises occur;
- Maintaining or increasing small but steady income flows to poor households, and increasing the ability to cope with economic stress;
- Enabling households to avoid irreversible strategies, such as the sale of income-generating assets and loss of future earning and productive capacity;
- Maintaining the viability of the community's informal safety net;

Strengthening the economic capacity of the community safety net is predicted to have increased impact on mitigating the effects of HIV/AIDS. Communities that have participated in mobilization around the issue of children affected by HIV/AIDS will be more likely to have developed systems for identification of vulnerable children and actions needed to address this population. In those communities, greater resource sharing is expected as economic growth results in stronger safety nets.

Throughout Zimbabwe, as in other regions throughout the world, organizations that focus on providing support to people living with HIV/AIDS have recognized the need for economic interventions and have initiated IGAs to address that need. Without the specialized skills necessary to develop, implement, and support these activities, many such well-intentioned efforts result in failure. There are many programs that specifically focus on strengthening household and community income; they currently, or have the potential to, contribute to increased economic capacity in communities affected by HIV/AIDS. The optimal approach, therefore, would involve a geographic overlap between those interventions that increase economic opportunities and those that focus on community mobilization as it relates to the needs of children affected by HIV/AIDS and their families

USAID/Zimbabwe has incorporated a unique opportunity to strengthen the relationship between economic opportunity support and HIV/AIDS mitigation. In addition to continuing ongoing support of microfinance in Zimbabwe, the mission has addressed HIV/AIDS mitigation as part of its Economic Opportunity Special Objective (SpO). The overall objective of the SpO is "to increase the access that disadvantaged groups have to economic opportunities that will have a measurable impact on their lives and livelihoods... throughout rural and peri-urban Zimbabwe." Two Intermediate Results (IRs) will be pursued, with a special focus on groups affected by HIV/AIDS. These will be: 1) increased access to financial services and 2) improved business capacity to micro-business groups. In addition, USAID/Zimbabwe will support specific SpO activities to provide training, business skills development, and microfinance services to generate income, protect assets, and reduce the vulnerability of groups of those affected by HIV/AIDS.

PROPOSED PRINCIPLES OF ACTION

The following points are also suggested for consideration by USAID, the GOZ, donors, NGOs, community groups, and others concerned with children affected by HIV/AIDS.

These are starting points for the development of further principles to guide program design and implementation.

- Facilitate the initiation of community-based responses to children and families affected by HIV/AIDS where they do not already exist.

- Strengthen the capacity of existing community-based responses for children and families.

- Support participatory community mobilization and community ownership as key to sustaining effective responses.

- Support sustainable volunteer commitment. Avoid actions or policies that undermine sustainable volunteer involvement.

- Direct services and activities to children according to their need, not their status as orphans.

- Support representative community processes to identify and prioritize children in need.

- Link prevention and mitigation efforts to maximize positive, synergistic effects.

- Link home-based care for PLWHAs and support for children who are affected by HIV/AIDS.

- Enhance the capacity of community responses to address the psychosocial needs of children affected by AIDS and their families.

- Encourage activities that involve youth as part of the solution and empower youth.

- Encourage cooperative problem solving and support information exchange among communities.

- Coordinate microenterprise activities with mitigation efforts to achieve synergies in both areas

- Provide material support in a manner that will not weaken community initiatives.

- Identify, implement, and evaluate models for increasing the scale of community approaches.

- Incorporate care for children affected by AIDS into related development programs (e.g., poverty reduction, education, water sanitation projects, nutrition activities).

- Emphasize coordination and collaboration among stakeholders as essential to maximize the impact of limited resources.

- Use monitoring, evaluation, research, and information exchange to generate lessons learned and best practices and to maximize project quality and coverage.

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List of Acronyms

CA	Contracting or cooperating agency
CBO	Community-based organization
CEDC	Children in especially difficult circumstances
CIDA	Canadian International Development Agency
CWF	Child welfare forum
DANIDA	Danish Development Agency
DSW	Department of Social Welfare
EC	European Commission
EFZ	Evangelical Fellowship of Zimbabwe
FACT	Family AIDS Caring Trust
FOCUS	Families, Orphans, and Children Under Stress Program
FOST	Farm Orphans Support Trust
FY	Fiscal year
GOZ	Government of Zimbabwe
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficienc Syndrome
HOCIC	Hope for a Child in Christ
IGA	Income-generating activity
IR	Intermediate result
LIFE	Leadership and Investment in Fighting and Epidemic
M&E	Monitoring and evaluation
NAC	National AIDS council
NACP	National AIDS coordination program
NGO	Nongovernmental organization
NORAD	Norwegian Organization for Relief and Development
NPACC	National Plan of Action for Children
ONAP	Office of National AIDS Policy
OVC	Orphans and vulnerable children
PLWHA	Person living with HIV/AIDS
RDC	Rural district council
SAT	Southern African AIDS Training Organization
SIDA	Swedish International Development Agency
SO	Strategic objective
SpO	Special objective
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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